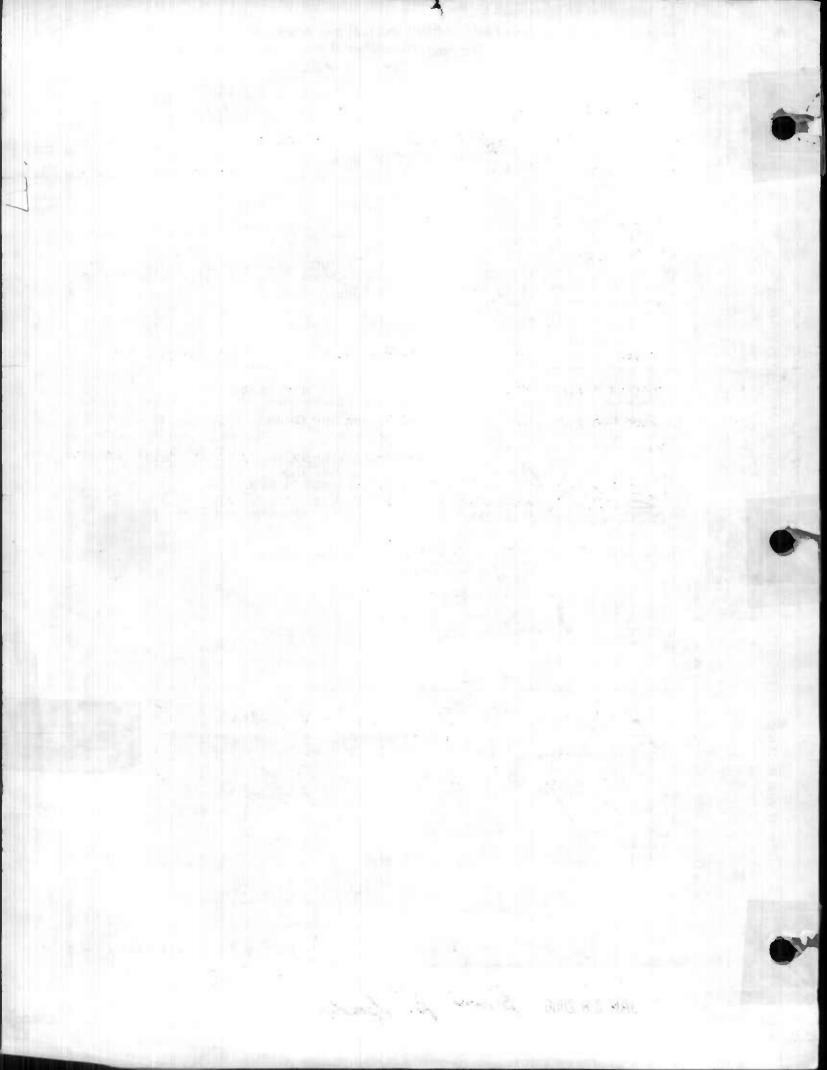
Please Type or Print In Black Indelible Ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year .40 **Physician** 24 2000 Gloria Emma Dandy JANUARY AM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner Lorien Nursing Home Riverside Belcamp HARF ORI If Under 1 Year | If Under 24 Hrs 5. Social Security Number 9. Birthpiace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2 Y F Months Days Hours Min. Yrs. 78 Director 214-12-9713 Oct.29,1921 Baltimore, MD. Usual Residence of Decedent 10a State 10c. City. Town or Location 10d. inside City Limits 10b. County id other than "naturel", or flems 23s or 28e-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 ♥ No Director Maryland Harford Fallston 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 408 Fieldstone Court 21047 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married 1 Yes 2 No Specify: þ 3 ₩ Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working tifa. DO NOT usa retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada completed) should be filed within Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. 12 yrs. Vice President Signet Bank n/a 18. Mother's Name (First, Middla, Maiden Sumame) 17. Father's Neme (First, Middla, Last) and Mental is marked Frederick William Seim Emma Eckelston 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Coda) 19e. Informant's Neme/Reletionship (Type, Print) Fallston, MD. 21047 Department of Health reportant: If Item 27 Linwood Dandy Jr. (Son) 408 Fieldstone Court 20b. Place of Disposition (Neme of cematary, cramatory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 nant of H 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Spacify) BelAir Memorial Gardens 1/27/2000 BelAir, MD. 21014 22. Name and Address of Facility
E.F.Lassahn Funeral Home 21. Signature of Funeral Service Licen 11750 Belair Road Kingsville, MD. 21087 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximate interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical hours ocard **Examiner** Physician/Medical Examiner Due to (or as e consequence of) that the death certificate be executed physician and the burial-transit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Records, P.O. Box 68760, Due to (or as a consequence of): ed by the a Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed by þ The law requires 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed completion of ceuse of deeth? cartificata has 1 Yes 2 No Following Division of Vital Physician: 25. Was dase referred to medicel examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 10 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funaral 28e. Dete of Injury (Month, Day Year) To the Heapital or Atlanding Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral 27. Menner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? Certification: 1 Natural 5 Pending 1 Yes 2 No Investigation 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Streat and Number or Rural Route Number, City or Town, Steta) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred et the time, dete and piece, end due to the ceuse(s) end manner es stated edical (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete and piece, and due to the cause(s) and manner stated. 29b. Signature and title of certifig 29c. License number 29d. Date signed (Month, Day, Year) 7010 2000 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) 0 LAZATIV MANUEL

2100

State Registrar M.

Registrar's

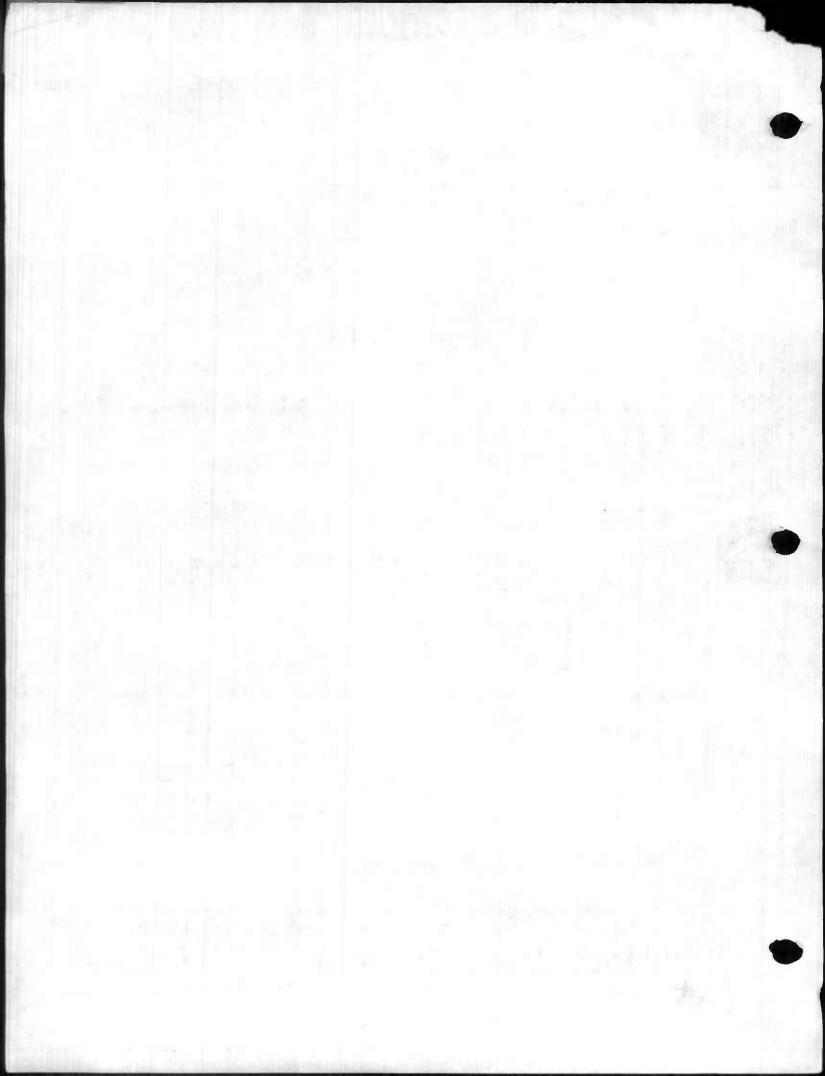


Please Type or Print In Black Indelibie Ink. Assure Ali Coples Are Legible.

| Physician | | | | | Certificate | of Death | R | eg. No. | 02 | 002 |
|---|--|---|---|---|---|--|--|--|--|--|
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| /Medical | to Facility Name (Mass hatt | BYNS aution aive st | treet and number |) | | 4b. City. Town, o | JANUAF Location of Death | 4c. County | | 2247 PM |
| Examiner | 3705 YOSEMI | | | | | BALTIM | | 10. 0001119 | NA | |
| * Funeral | 5. Social Security Number | 6. Sex | 7. A | ge (In yrs. last bi | Months D | eer If Under 24 Hr | | Year) | 9. Birthplece Country) | (State or Foreign |
| Director | 219.44.8683 Usual Residence of Deceden | | | 75 | Yrs. | | 03-10- | 24 | | /A |
| how Lat | 10a. State 10b. Cou | | | 10c. City, Tov | n or Location | | | | | nside City Limits |
| viih the Ma t or 28a-f s be notified Director | mo | NIA | | BALTIN | | | | | | Yas 2 No |
| lar death with the Maryin Herms 23s or 28s-f sho Instrinual be notified at Tuneral Director | 10e. Street and Number | - 1 | | | 10f. Zip Co | de OIE | 1 | Og. Citizen of V | Vhat Country? | |
| r Items 23s sloer must Funeral | 3105 YOSIMIT | | NUE 2. Wes Decedent | Ever In U.S. | 13. Was Deceden | of Hispanic Origin? (Cuben, Mexican, Pue | Specify Yes or No- | | 9 - American II | ndian, |
| 1 E | | | Armed Forces | | 1 Yes 2 | / | nto Hican, etc.) | Specify | k, Whita, etc. | |
| al Engl | | rced edent's Educa | Year or Detes: | 164 | . Decedent's Usual C | ccupation | | 16b. Kind of Bu | BLACK | |
| Medic Medic | (Specify only his Elementery/Secondary (0-1 | ighest grede | | | (Give kind of work of life. DO NOT use r | one dunna most of w | orking | | 10000 | |
| We than 'natural, it, the Medical Completed | 1 TH GRADE | | NA | | LABORER | | | +ACTO | | |
| Be well | 17. Fether's Name (First, Mid | | | | | 1 | 18. Mother's Name (First, Middle, Meiden Sumeme) | | | |
| umartic | 19a. Informent's Name/Relat | | e, Print) | 19 | o. Mailing Address (S | BESSIE Treet end Nymber or F | CAMPBE Rural Route Number | ELL nber, City or Town, State, Zip Code) | | |
| er tra | INEZ FALIN | Sig | STER | 40 | 25 FREDE | CICK AVE. | BALTIMO | RE, M | 10. 212 | 29 |
| ar oth | 20a. Method of Disposition 1 ☑ Buriel 2 ☐ Cremati | ion 3 □Re | moval from State | cemete | of Disposition (Neme ory, crematory or othe | plece) | Dete | 20c. Location - | City or Town, | State |
| mportant uny injury 2028. | 4 Donation 5 Othe | or (Specify) | | MT. ZI | ON CEMET | ERY ddress of Facility | 1-24-2000 | BALTO. | mo | |
| 4 | 21. Significate of Porteral Service | rice Licensee | · U | | VAUGHN C | GREENE | FUNERAL | SERVIC | E | |
| | 23a. Part1. Enter the disease shock, or healt failure. | e, or complice | etions thet cause | d the death. Do | not enter the mode o | O. NATE PIK | ec or respiretory are | mo. 2 rest, | | proximete prvst Between |
| /sician | STICK, OF HEALT TOPICE. | List Only One | | | | | | | On | set and Death |
| ledical aminer | Immediate Cause (Final disease or condition resulting in deeth) | a. | ATIte | MOSA | onotre | CAMINI | Scarp 1 | usos. | | |
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| in and rial-transit Examiner | Sequentially list conditions, | b . | | Due to (or as a | consequenca of): | | | | 1 | |
| e in X | Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying | | | | | | | | 1 | |
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| the bu | Ceuse (Diseese or Injury thet initieted events resulting in death) Last | | | | consequence or). | | | | i | |
| nding physicie use as the bu | Ceuse (Diseese or Injury thet initieted events resulting in death) Last | d | | | consequence or). | | | | | |
| nding physicie use as the bu | Ceuse (Diseese or Injury thet initieted events resulting in death) Last | d. ditions contr | ibuting to death t | out not resulting | | e given in Pert I. | 23b. Did to | obacco use co | ntribute to the | causs of death? |
| d by the attending physicial etached for use as the but Physician/Medical | Ceuse (Disease or Injury thet initiated events resulting in death) Last Part tt. Other significant con- | d. | ibuting to death b | out not resulting | | e given in Pert I. | | obacco use con ′es 2□ No | ntribute to the | |
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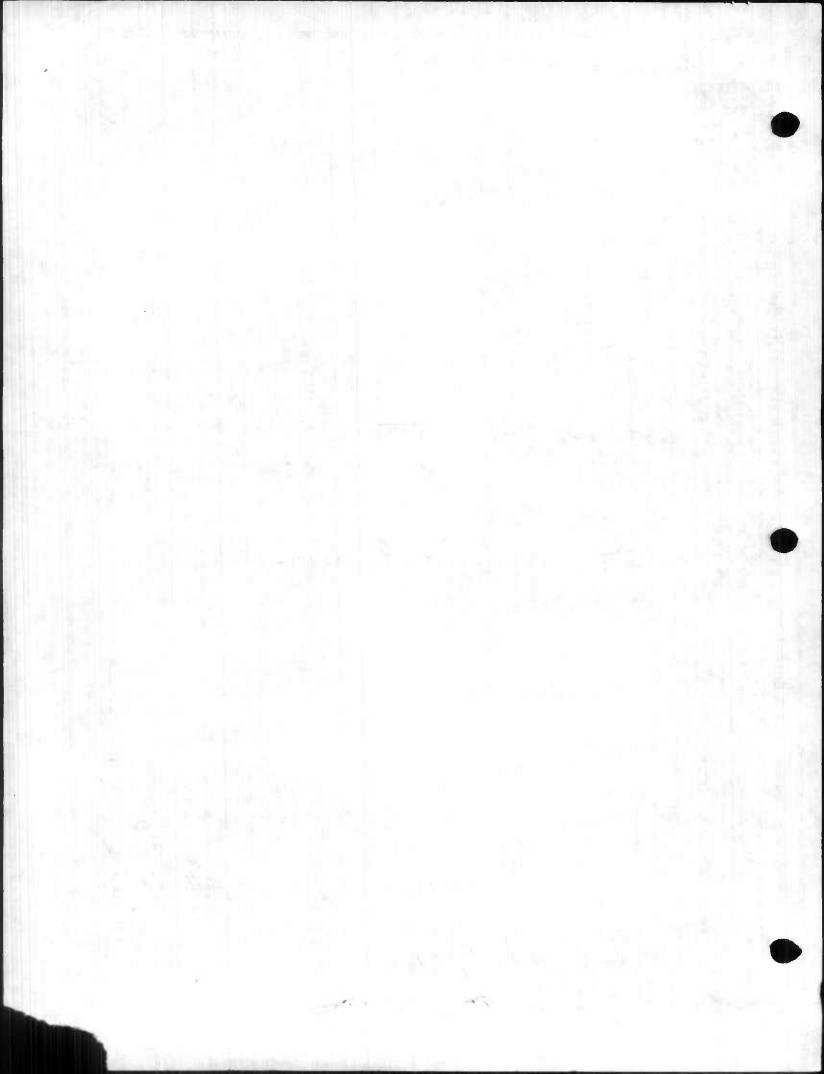
Registrar DHMH 16 Ray 6/95

JAN 2 8 2000



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| SP | DWARDS State of Maryland / Departme Item: 19b, per F.H G-779 1/28/2000 reb Certifica | nt of Health and Mental H | ygiene Reg. No. | 2003 |
|---|---|--|-------------------------------------|--|
| Physician /Medical | 1. Decedent's Name (First, Middle, Last) Haron Dondre Lowards 4e Facility Name (If not institution, give street and number) | 2. Dete of 0 Month JANUA 4b. City, Town, or Location of De- | RY 18 2000 | 3. Tima of Death 2322 |
| Examiner Funeral Director | 3320 ERDMAN AVE | BALTIMORE or 1 Year If Under 24 Hrs. 8. Dete of E. Month, U. | Birth 9. Birth Co | hpiece (Stete or Foreigntry) Nazy land |
| death with the Maryland ms 23a or 28a-f show must be notified at neral Director | 10a. State 10b. County 10c. City, Town or Location Haryland none Balfinere | | | 10d. Inside City Limi 10XYes 2□N |
| leath with the Marylar The 23a or 28a-f show The 15a routled at | 106. Street and Number 101. Z 2433 Seamon Aue. | 1235 | 10g. Citizen of What Co | untry? |
| ar, or he by Fu | 11. Meritel Status 12. Wes Decedent Ever in U,S. Armed Forces? 12. Wes Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yes, Give Yeer or Detes: | edent of Hispanic Origin? (Specify Yes or I ecify Cuban, Mexican, Puerto Rican, etc.) | Specity: | |
| ygiene. er than "natural", t, the thedral Earl Completed by | Elamentary/Secondary (0-12) Cottege (1-4or 5+) life. DQ NOT | vork done during most of working use retired) | 16b. Kind of Business | |
| T S S | 17. Fether's Neme (First, Middle, Last) | 18. Mother's Neme (First, Midd | | |
| Department of Health and Ments Important: If Itam 27 is marked any injury or other traumatic are once. To E | 20e. Method of Disposition 1 Removel from State 4 Donetion 5 Other (Specify) 20b. Place of Disposition (Name of Comments) 20c. Place of Disposition (Name of | ss (Street and Number or Rurel Route Number or Rurel Route Number or Rurel Route Number of Other place) Memoriae Memoriae W. Franklin St. | . / | nd ab: |
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| within 24 hours after death. To the Funeral Director. After this certificata has completaly filled in by the funeral director, page 2 Medical Certification: To Be Comp | Hospitel: I Inpatient 2 ER/Outpatient 3 1 | esidenca 6 MOther (Spe the how injury occurred Specification of Specification of Specificat | A | |
| in 24 hours he Funeral pletaly fille edical C | 29e. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deeth occurre 2 Medical Examiner: On the basis of examination end/or investigation and menner stated. | | | |
| To the comp | 296. Signature and title of cartifler Theodore M. Kirk ~w | 9c. License number O.C.M.E | 29d. Date signed (Mon JANUARY 19 | |
| 4) State | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TONONE M. Ku-9 31. Deterfiled (Month, Day, Year) 2. Regions & Signature | 1 Penn Street, Balt | imore, Maryl | and 21201 |



Physician /Medical Examiner

Funeral Director

with the Maryland show 28a-f re 23e or Neme filed within 72 hours after Hygiena. Pages 1 and 2 should be filed witnessed of Health and Mental Hygier fant: If fem 27 is marked other th funy or other trainmatic event, the

21215-0020

altimore, Maryland

Physician /Medical Examiner

Department of important: If any injury or

The law requires that the death certificate be executed physician s the burial Box 68760, for use as signed by the at d be detached for P.0. Division of Vital Records, page 2 certificata Attending Physicien: funeral director, After this after death. Director: Aft the To the Hospital or Atterwithin 24 hours after dea To the Funeral Director completely filled in by th

1. Decedent'a Nama (First, Middle, Last) 3. Time of Death Year ECK FRANCES TANUARY 18:05 22,2000 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Johns Hopkins Bayview Medical Center Baltimore N/A 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Months Hours 1□M 2QF 219-16-9453 81 06-12-1918 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Dundalk 1 ☐ Yes 2 ☑ No Maryland Baltimore Directo 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 21222 USA 3105 Short Way Funeral Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U,S. Armed Forces? 14. Rece - American Indian, 11. Marital Stetus Bleck, White, etc. 1 Yes 2 No If Yes, Giva Year or Dates: 1 Never Married 2 Merried 1 ☐ Yes 2 ☐ No Specify: Specify: White ģ 3₺ Widowed 4 Divorced Completed 16a. Decedent'a Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Education 6 Years Teacher's Aide 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 80 Martina Ruark Howard Robinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John F.Eck, Jr. (Son) 305 Retford Way Apt L Baltimore, MD 21220 20b. Place of Disposition (Name of cemetary, crematory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete H Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 1/27/00 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland Oak Lawn Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility The Duda-Ruck Funeral Home of Dundalk, Inc. A Klide 23a. Part1. Entar the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on aach line. Approximate Interval Between Onsat end Death Immediata Causa (Finel PNEUMONIA DAYS disease or condition resulting in deeth) CHLONIC OBSTRUCTIVE PULMONARY DISEASE 20 Examiner Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? SUBBURAL HEMATOMA 15 Yea 2 No 3 Probably 4 Unknown Completed by 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? HOLTER' 1 Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only ona) Hospital: 1 Appatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident 1 Tes 2 No 6 Could not be determined 281. Location (Street and Number or Rural Route Number, City or Town, Stata) 3 Suicide 28e. Place of Injury - At homa, farm, street, factory, office building, alc. (Specify) 4 Homicide 29a, Certifier (Check only one) 15d Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at tha time, data and place, and due to tha cause(s) and manner stated. Medical 29b. Signature and title of clanding 29c. License number 29d. Dete aigned (Month, Day, Year) M.D. RES-000 TANUARY 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NORTH WOLFE STREET BALTIMORE ROSSON 600 GEDGE

State Registrar

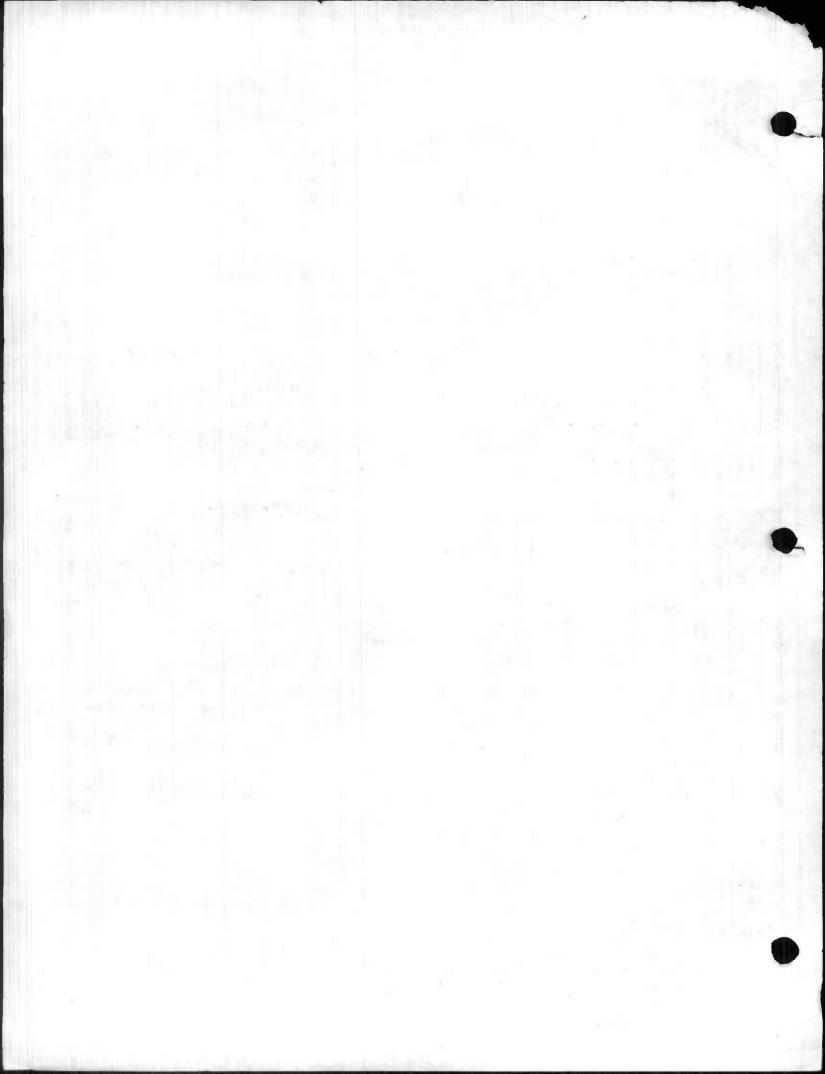
31. Date filed (Month, Day, Year)

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32. Registrer's Signature

Deneva



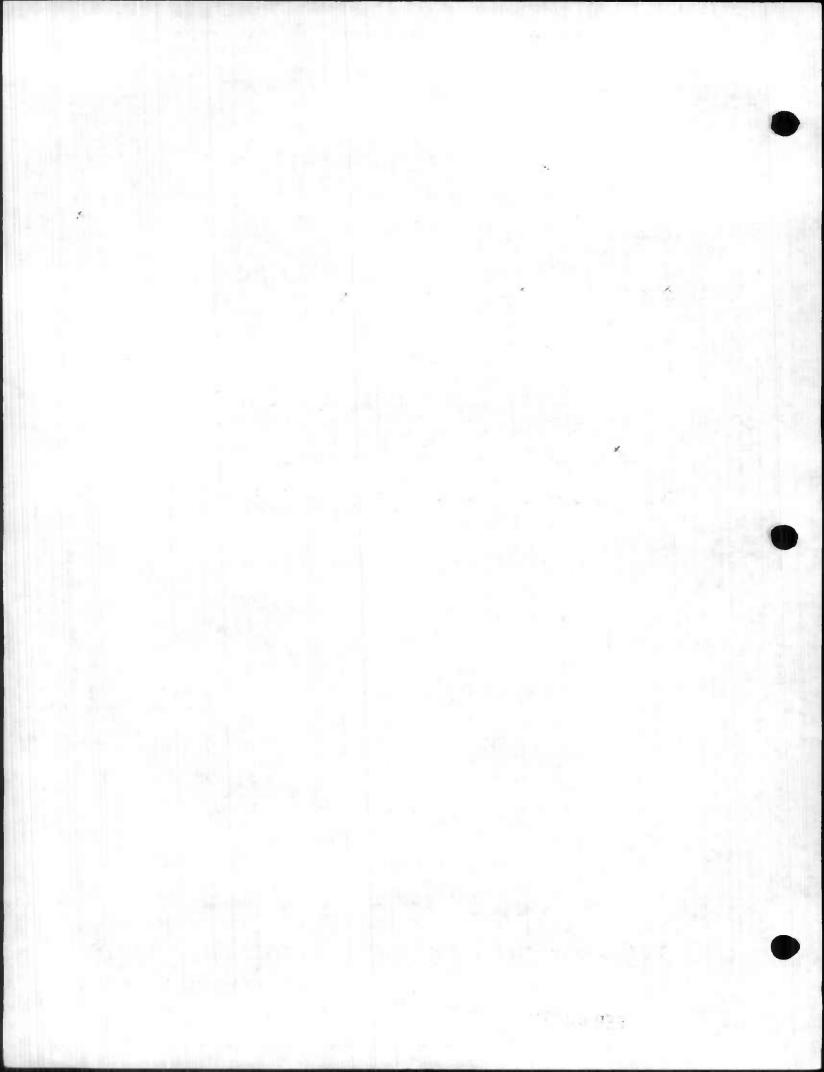
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| | 3 | Social Security N 366-16-77 | 747 | 6. Sex 1 ⊠ M 2□ F | A A - Ab - D | | | | | 24 Hrs. Min. | 8. Date of Birt (Month, De 06 24 | h y, <i>Year)</i> 1921 | 9. Bi | inhplace (S Country) Mi | tete or For |
| ahow sdat | - | Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location | | | | |) | | | | | - | 10d. Ins | Ida City Lir | |
| be notified. | | Md N/A Baltimore | | | | | | | | | | | | Yes 2□ | |
| important; If item 27 is marked other than "natural", or items 23s or 28s-f shot any injury or other traumatic event, the Medical Examinar must be notified at once. To Be Completed by Funeral Director | | | | | | | | | | | 10g. Citizen | USA | ountry? | | |
| | | Marital Status Marrial Status Marrial Status Marrial Status Midowed | Armed I | | in U,S. | If Yas, | ea 2/2 N | ıban, Mexicai | n, Puerto | ecify Yes or No- Rican, atc.) | | Black, Wh | nerican Indi lite, etc. hite | an, | |
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| Ě | · | 9a. informant'a Na | | | | 19h | Mailing Add | dress (Stre | | | | ar City or To | wn State | Zio Code) | |
| | | George Ev | | | | | | | | | ton, CT | | City or Town, State, Zip Code) 06013 | | |
| | 20 | 0a. Mathod of Disp 1 ☐ Burial 2 4 ☐ Donation | Cremation | 3 Removal from | m State | cemete | f Disposition ry, cremetory .more V | or other p | | em. | Date | 20c. Locati | | | ate |
| an call examiner | In | 23a. Part1. Enter the | rt failure. List o | only one cause or | n each line. | | | | | | | | | Interv | el Betwee |
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Enps Cecelia 212000 /Medical 4c. County of Death 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death Examiner more Arc If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland If Under 1 Yea 7. Age (In yrs. last birthday) 5. Social Security-Number 6. Sex **Funeral** 1 M 2 F Hours Months 216-34-9495 Yrs. **Director** Usual Residence of Decedent 10b. County 10e. Stete 10c. City, Town or Location 10d. Inside City Limits r than "natural", or fleme 23a or 28a-f show the Medical Examiner must be notified at altimore NIA B 1 Yes 2 No Md Director 10f. Zip Code 2122 10e. Street and Number 10g, Citizen of What Country? Rd USA SI4 Coventry 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces 1 ☐ Yes 2 ② No If Yes, Give Yeer or Detes: 14. Race - American Indian, 11. Merital Status Black, White, etc. 1 Nevar Married 2 ☐ Married 1 Yes 2 No Baltimore, Maryland 21215-0020 Specify: Specify: Black p 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry pernit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "reary injury or other traumatic event. The Mental Contract of the Mental Con Elementary/Secondery (0-12) College (1-4or 5+) Heath Care NUTSC 12 45 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Bigger Hurd Alice Jam cs 19a. Informant's Neme/Relationship (Type, Print) Daught (19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Sy coventre Rd Baltomd Roles 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Dete Caton suille 1-27-200 etro Cremetory 4 ☐ Donetion 5 ☐ Other (Specify) Baltmore NAM PIKE 21. Signeture of Funeral Service Licensee 22. Name and Address of Fecility 51 51 C Green & Guneral Scruce > Vaughn 23a. Part1. Enter the Misese, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) Examiner Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initieted events rasulting in death) Last Completed by Physician/Medical Due to (or as e consequence of). Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Nes 2 No 1 Yes 2 No Be 25. Wes case reterred to medical axeminer? 26. Piace of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2N No 1 Inpatient 2 ER/Outpatient 3 DOA Division of this 27. Mannar of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) After 1 Accident 5 Pending after death. Director: Aft 1 ☐ Yes 2 ☐ No investigetion 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 6 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end mannar steted. edicai 29e. Certifie (Check only one) within 2 29b. Signatura and Alle of certifier 29c. License number Completed cause of Seath (Item 23a) (Type, Print) 30. Neme and address of pers Jr. XON 32. Registrar's Signature 31. Dete tiled (Month, Day, Year) State JAN 2 8 2000 Registrar DHMH 16 Ray 6/95

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Month Year **Physician** adeline FRIEdman 20 2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner MARBOR altimore HOSPITAL CENTER If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) If Under 1 Year Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months 10 M 20 F 88 Yes Director 1911 Maryland 215-05-0530 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at XXYes 2□No N/A Director Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1201 Battery Avenue 21230 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces?

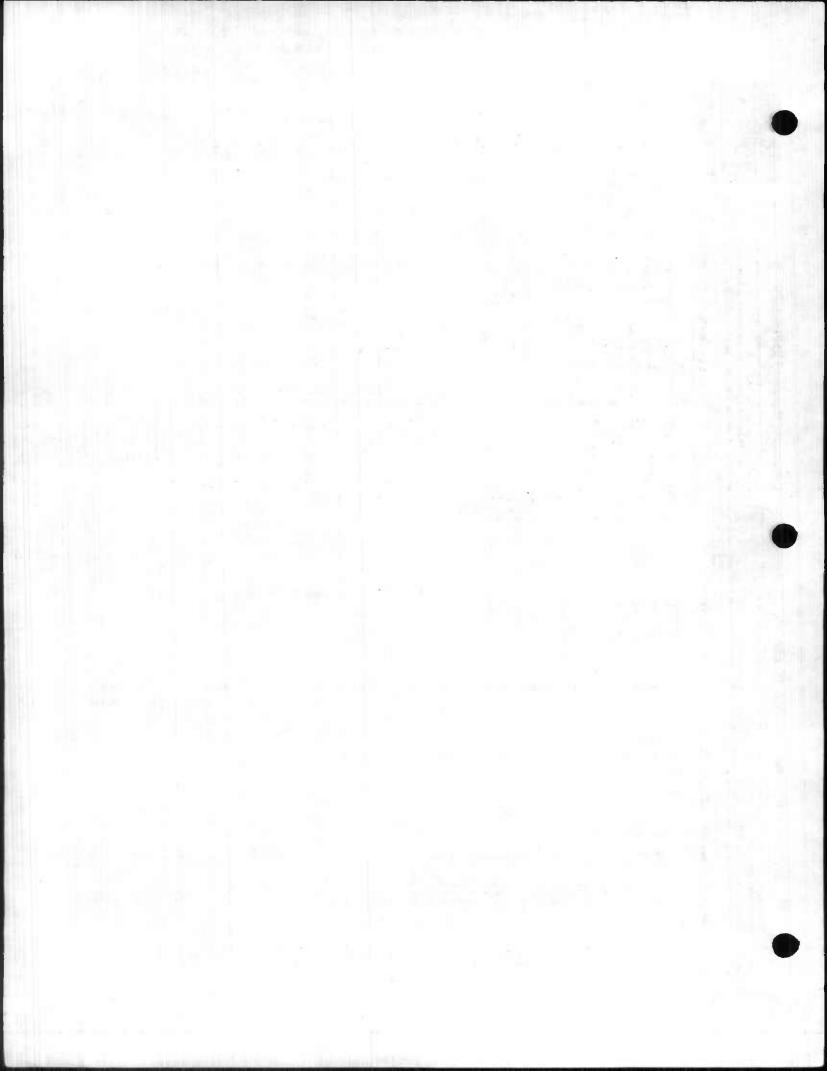
1 Yes 2 XNo
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Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours effer Hyglene. Wher than "netural", or its 1 Never Married 2 Married aitimore, Maryland 21215-0020 specify: White 1 Yes 2 XNo Specify: 2 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) 7th Grade N/A Homemaker Home Owner permit. Pages 1 and 2 should be filed Department of Health and Mentel hyg Important: if them 27 to marked other eny injury or other treumstic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 8 Albert Smith JoAnna Welsch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 209 W. McComas St. Baltimore, MD Alva Brown-Niece 21230 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Data 1 ☐ Burial 2 【Cremation 3 ☐ Removal Irom State Greenmount Crematory 1/24/00 Balto., MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility McCully-Polyniak Funeral Home, PA lton 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate tntarval Between Onsat and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of): oneumonia physician and s the burlei-transit The law requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical Due to (or as a consequence of): US0 25 P.O. Part It. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the causs of death? i signed by the 1 Yes 2 No 3 Probably 4 Unknown SEVERE DEHYDRATION Records, þ 24b. Were autopsy lindings available prior to completion of cause of death? Completed 24a. Was an sutopsy 1 Yes 2 No 1 Yes 2 No certificate Division of Vital To the Hospital or Attending Physicien: within 24 hours effer death.

To the Funeral Director: Affer this certifica completely filled in by the funeral director, I 25. Was case referred to medical 8 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) Hospital: 12 Inpatient 2 ER/Outpetient 3 DOA 1□ Yes 2 No edical Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? Natural 5 Pending investigation 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 16 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Data signed (Month, Day, Year) eonie ne and address of person who completed cause of death (Item 23a) (Type, Print) S. Hanover Street Baltimore onie Clar 31. Date filed (Month, Day, Year) State

DHMH 16 Rev 6/95

Registrar

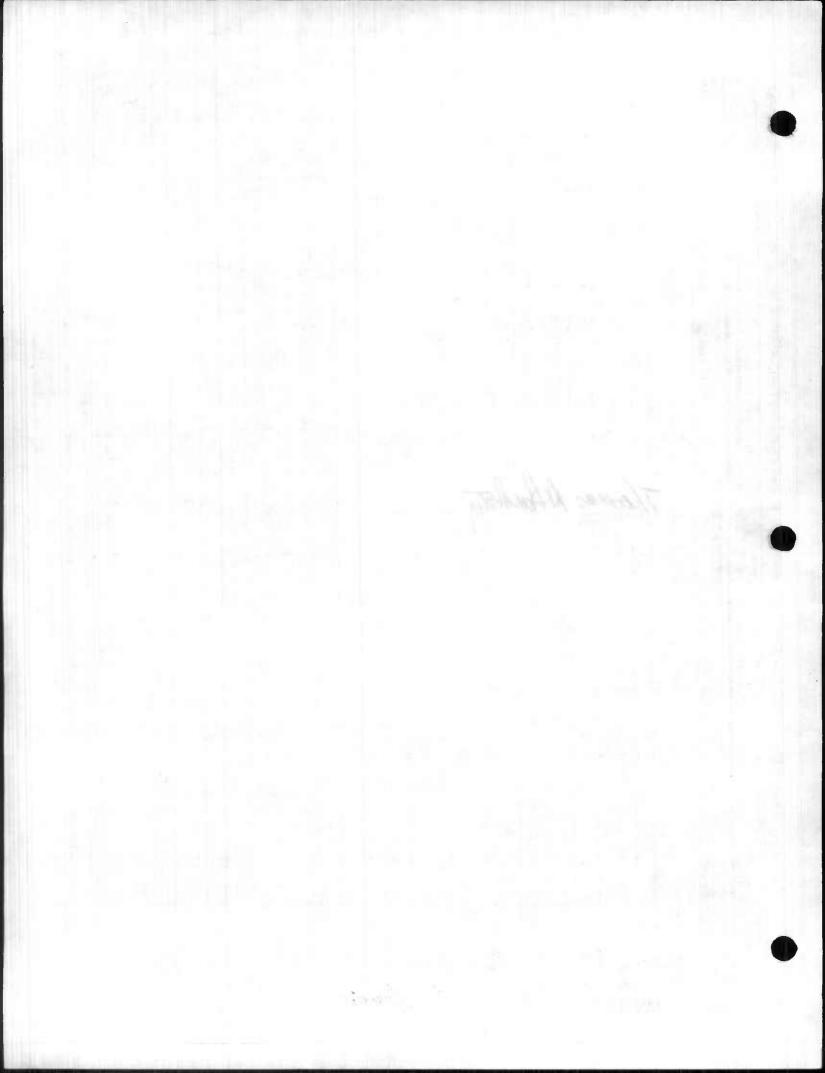
JAN 2 8 2000



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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Year **Physician** 2000 Nathan Finkelstein January 21 /Medical 4a Facility Nama (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** EASTHAM Court Crofton Anne Arundel If Under 24 Hrs. If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthdey) 8. Dete of Birth (Month, Day, Year) **Funeral** Days Months Hours 1 M 2 □ F 86 Yrs. 101-05-0376 Oct. 1, 1913 New York **Director** Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits ahow. 1 Yes 200No Director Crofton Anne Arundel 288-1 10a Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 900 Eastham Court Berra 23a 21114 USA Funeral 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 1 N Yes 2 No 14. Rece - American Indien, 11. Meritel Stetus Bleck, White, etc. filed within 72 hours after 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 'natural', or Specify: White 1 ☐ Yes 2 ☑ No Specify: ğ 3 ☑ Widowed 4 ☐ Divorced Yeer or Detes: WWII Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Postal Worker Mail 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) 89 Pages 1 and 2 should be nent of Health and Mental To William Finkelstein Rebecca Feigelman 19a. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 2 Bruce Finkelstein (Son) Important: If Item 27 any injury or other to 900 Eastham Court, Apt. 34, Crofton, MD 21114 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, Stete tery, cremetory or other piece) 01/23/ 1XXBuriel 2 ☐ Cremetion 3 ☐ Removel from Stete New Montefiore Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Farmingdale, NY 22. Name end Address of Facility 21. Signature of Fulneral Service Licenses Hardesty Funeral Home, P.A. 23a. Pent! Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heer feiture. List only one ceuse on each line. 12 Ridgely Avenue, Annapolis, MD 21401 Approximate Interval Between Onset and Deeth **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical Anteriosclerotic Heart Disease UNKNOW Examiner Examiner sician and buriel-transit that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Couse (Disease or injury that initialed events resulting in death) Last Due to (or es a consequence of): Box 68760. Physician/Medical the th Due to (or es a consequence ol) P.O. signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records. Š 24b. Were eutopsy findings available prior to 24a. Was an eutopsy performed? Completed completion of cause of death? 1 Yes 2 No 1 Yes 2 No Division of Vital or Attending Physician: Be 25. Was case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Dete of Injury (Month, Dey Year) 27. Menner of Death 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? Atter 1 Neturel 5 Pending 1 Yes 2 No death. Investigation 2 Accident after deat 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a Hospital 29e. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and due to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) and mannar stated. Medical (Check only one) within 2 å, 29c. License number 29b. Signeture end title of certifier 29d. Dete signed (Month, Day, Year) 006054 00 Name and address of person who completed (suse of death (Item 23a) (Type, Print) 695 America 00 e6/40 32 Regittrar's Signature State Registrar DRMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Irvin Watson Fowble Jr. 25 2000 6:16 p.m. Jan. /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Co. Gen. Hospital Westminster Carroll If Under 24 Hrs. 8. Date of Birth Nov. 29, 1932 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 9. Birthplace (State or Foreign Funeral Days Months Hours Maryland 218-32-0806 67 Yrs Director Usual Residence of Decedent with the Maryland 10a. Stete 10b. Counts 10c. City, Town or Location ahow ! 10d. Inside City Limits "natural", or items 23a or 28a-f ahov 1 Yes 2 No Carroll Director Maryland Manchester 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 2814 Ebbvale Rd. 21102 U.S.A. Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 1 Yes 2 No If Yes, Give 955 19 11 Marital Status Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: if fem 27 is merked other than "natural", or her important: if fem 27 is merked other than "natural", or her by Injury or other traumatic event, the Mexical Exercities page. 1 Never Married 2 Married aitimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White 1957 by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 10 Truck Driver Paving 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Irvin Watson Fowble Sr. Viola Blanche Cullison 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Louella Mae Fowble- wife 2814 Ebbvale Rd. Manchester, Md. 21102 20e. Method of Disposition

Burlal 2 Cremetion 3 Removel from Stete 20b. Place of Disposition (Name of Date 20c. Location - City or Town, Stete tery, crematory or other place) Marburg Mem. Gardens Jan. 29, 2000 Hanover, Pa. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funerel Service Licenses 22, Name end Address of Facility Eckhardt Funeral Chapel ustin 3296 Charmil Dr. Manchester, Md. 21102 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock or heart fellure. List only one cause on each line. Approximate Intervet Between Onset and Death **Physician** /Medical Immediate Cause (Final diseese or condition resulting in death) Examiner Due to (or as a consequence of) Examiner The law requires that the death certificate be executed nding physician and use as the bunal-transit Sequentietly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical Due to (or as a consequence of) P.O. Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert 1. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown been signed by should be detac 1 Yes 2 No Records, by Completed 24b. Were autopsy lindings available prior to 24a. Was an autopsy performed? complation of cause of death? page 2 s certificate 1 Yes 2 DNo 1 Yes 2 No Division of Vitai To the Hospital or Attending Physician: funeral director, 25. Wes case referred to medicat examiner? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 1 Inpatient 2 DER/Outpatient 3 DOA this 27. Menner of Death 28d. Describe how injury occurred 28e. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After 1 Natural 5 Pending s after death. 1 Yes 2 No Investigation 2 Accident filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, lerm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral D completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and menner stated. 29e. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature d title of certifier 29c. License number 30. Name end.address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 16 Rav 6/95

State

Registrar

31. Dete filed (Month, Day Year,

JAN 28 2000

Heights, Westminster, MD 21157

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Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent'a Name (First, Middle, Last) 2. Date of Death Mildred . J. FREDRICK January Day 25 Year 4-20 AM 2000 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Frederick Villa Nursing Home Catonsville **Baltimore** H Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Aug. 25, 1915 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number Birthplace (State or Foreign Country) 1□ M 2 F 212-20-8947 84 Vrs Virginia Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Tyes 2X No. Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5912 Charnwood Road 21228 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify: White 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Cashier Dairy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Irvin Wheeler Jenkins Merca Lee Dodson 19a. Informant'a Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5912 Charnwood Road, Baltimore, MD 21228

e of Disposition (Name of Date 20c. Location - City or Town, State Roy M. Fredrick (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from State 1/28/00 Woodlawn, Maryland Woodlawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Edheral Service Licensee 22. Name and Address of Fecility Witzke Funeral Homes, Inc. 1630 Edmondson Avenue, Catonsvile, MD 21228 useelle 23a. Part1. Enter the disease, or complications that consed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on one in line. Onset and Death Immediate Cause (Final BRONCHOPNEUMONIA one hear disease or condition resulting In death) CARCINOMA COLON Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23b. Did tobacco use contributs to the cause of death? 1 Y88 2 No 3 Probably 4 Unknown ALZHEIMER'S DEMENTIA 24b. Were autopsy lindings available prior to completion of cause of death? 24a. Was an autopsy performed? OSTBO ARTHRITIS 1 ☐ Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpetient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Examiner physician and the bunal-transit Box 68760, Physician/Medical P.O. signed by t Records, à Completed certificate Division of Vital Be Medical Certification: To

Physician

/Medical

Examiner

Director

Funerai

þ

Completed

Funeral

Director

7 is marked other than "naturel", or items 23a or 28a-f show traumatic event, the Madical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after I Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturel", or Iter any Injury or other traumatic event.

Physiclan /Medical

Examiner

Baltimore, Maryland 21215-0020

the Maryland

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica complately filled in by the funeral director; §

State Registrar

29a. Certifier

29b. Signature and title of certifier

29c. License number D.30469

Terrifying Phyaician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

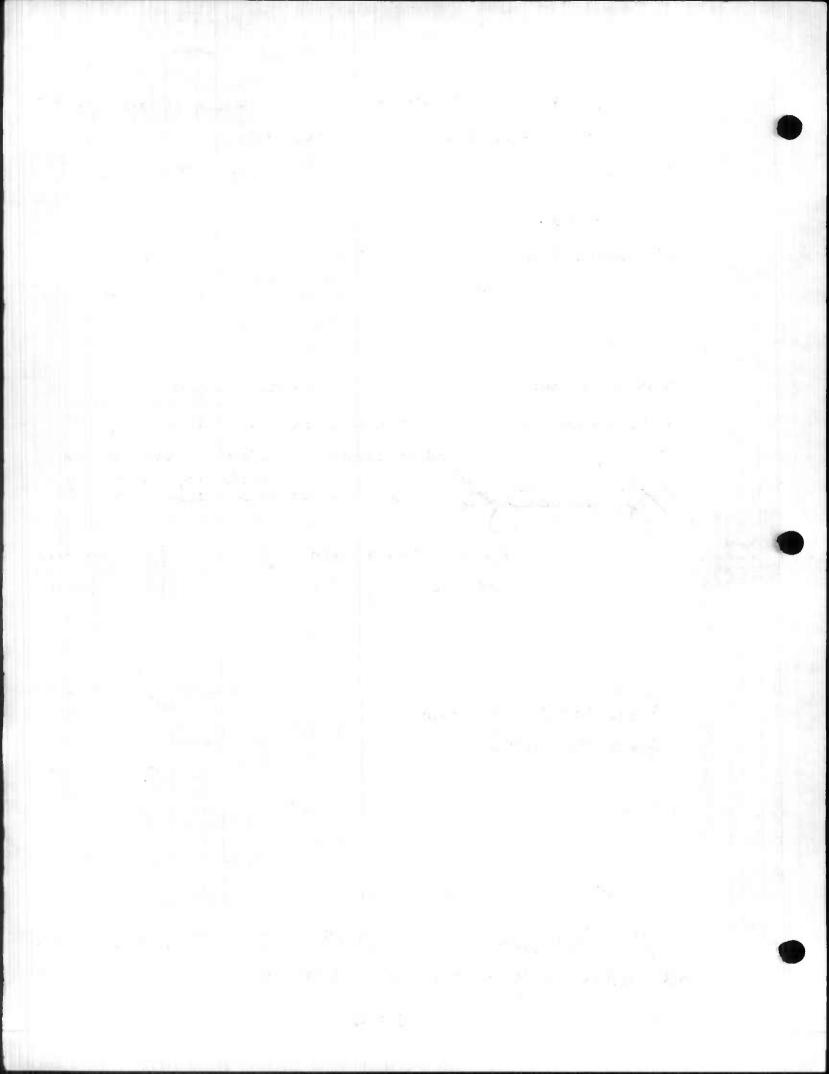
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year) January 16.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N.B. VRLLANK: 9055, CHEVROLET PRIVE: # 100: BUICOTT CATY: MD. 21642

31. Date filed (Month, Day, Year) 32. Registrar's Signature 28 2000

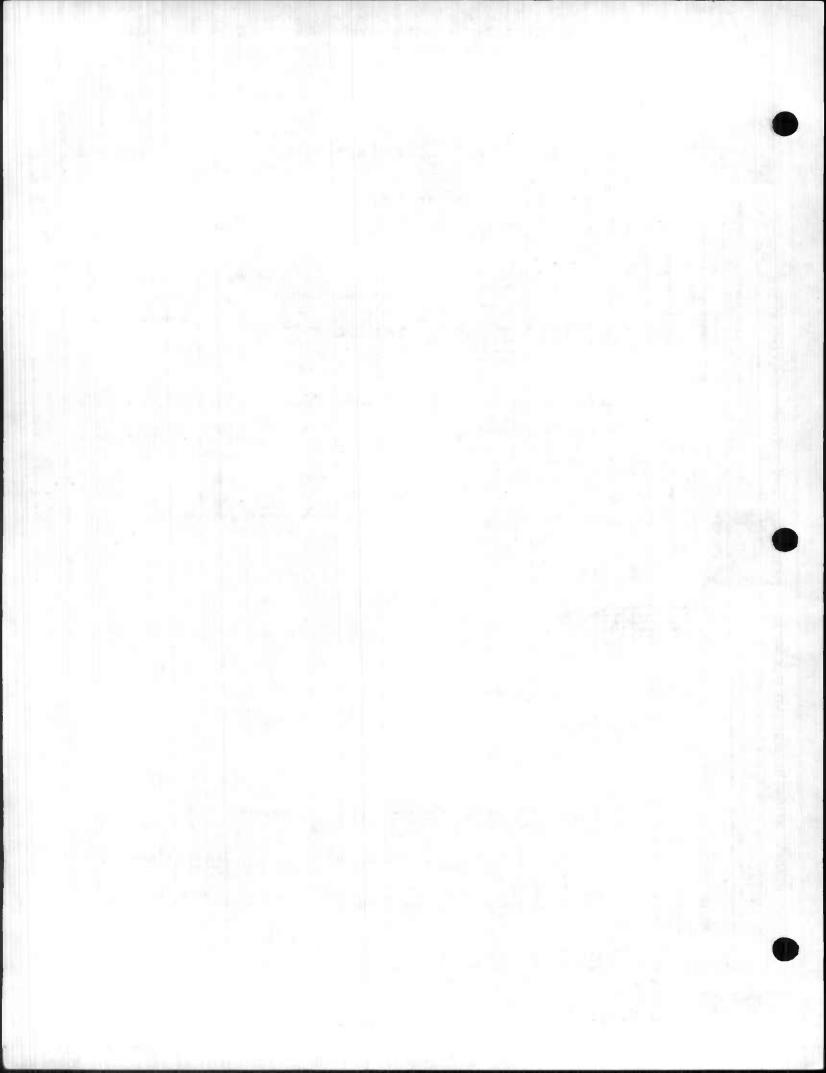


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State of Maryland / Department of Health and Mental Hygiene

| | | | 1. Decedent's Na | me (First, Middle, I | .ast) | | Cer | tificate of | Dealli | 2. Date of Dec | | | s of Death | |
|---------------------|---|-----------------|--|--------------------------------------|--|---------------------------------------|------------------------------------|--|---|--|---|--|---------------|--|
| | Physici /Medic | | HAZEL | FOWLKES | | | | | | JÄNUAR | y 22, 20 | 50 1 | 6:42 | |
| | Examir | | 4a Facility Name (if not institution, give street and number) HARBOR HOSPITAL CENTER | | | | | | | ty, Town, or Location of Death 4c. County of N/A | | | | |
| | Funeral Director | | 5. Social Security 213-14 | 4-4294 | Sex 1□ M 2只F | | last birthday) 79 Yrs. | If Under 1 Year Months Day | | 8. Date of Birth Month, Day 9-12- | 2 (par) | D. Birthplace (Sta Country) MD | | |
| | | | Usual Residence 10a. State | of Decedent 10b. County | | 10c C | ity Town or Lo | cation | | | | 10d Ineid | e City Limits | |
| | Aeryle a tho | 5 | MD. | N/A | | 10c. City, Town or Location BALTIMORE | | | | | | | es 2 No | |
| | h the Merylen r 28e-f ahow notified at | Tect | 10e. Street and N | | | | ALITION | 10f. Zip Code | | | 10g. Citizen of Wh | at Country? | | |
| | ter deeth wit from 23a o from must b | 0 | (72 AT | OUTERU OF | ADE (| D | | | | | IICA | | | |
| | | nera | 11. Marital Status | SQUITH ST | | edent Ever in l | J,S. 13. V | | 2 <u>15</u> Hispanic Origin? (S Iban, Mexican, Puert | pecify Yes or No- o Rican, etc.) | USA 14. Race - Black | American Indian White, etc. | 10 | |
| Maryland 21215-0020 | | P | | rried 2√ Married 4 □ Divorced | | 2 No | | □Yes 2ÅN | | , | | BLACK | | |
| 5-0 | neturel', | P | (Sp | 15. Decedent's ecify only highest of | Education rade completed) | | | a. Decedent's Usual Occupation (Give kind of work done during most of wo | | king | 16b. Kind of Busi | ness/Industry | | |
| 121 | within ene. | Completed | Elementary/Se- | | | College (1-4or 5+) life. DO NOT | | | red) | | BEAU | rv | | |
| 9 | Hygier ther th | | | e (First, Middle, La | | -02 COSPETICS | | | | ne (First, Middle, | Maiden Sumame) | | | |
| an | d be sed o | To Be | UNKNOW | V | • | | | | | HILL | | | | |
| ary | M Pu | - | 19a. Informant's | Name/Relationship | (Type, Print) | | 19b. Mailin | g Address (Stre | et and Number or Ru | ıral Route Numbe | or, City or Town, St | ate, Zip Code) | | |
| | eith 27 is r tre | _ 1 | GERALDI | INE GRAHA | M(DAUGHT | ER) | 3025 | JANICE A | AVE. BALT | IMORE, M | ARYLAND 2 | 21230 | | |
| Dre | Mem of He | | 20a. Method of D | | | | Place of Dispo | sition (Name of natory or other p | | Date | 20c. Location - C | |) | |
| Ĕ | permit. Pages 1 and 2 should be filed within Department of Heelth and Mentel Hygiens. Important: if item 27 is marked other than eny injury or other traumatic event, the Mentel Ance. To Be Compl | | | 2 Cremation 3 5 Other (Spec | | CE | DAR HIL | L CEMET | ERY | 1-29-200 | O GLEN BI | JRNIE, M | ARYLANI | |
| Baltimore, | | | 21. Signatura of I | Funeral Service Lic | enges H | Brew | | . Name and Add | · MONROE | | FUNERAL I | | | |
| | _ | П | 23a. Parti, Ente | r the disease, or co | mplications that c | aused the dea | | | ying, such as cardiad | | | Approxi | | |
| | Physician /Medical Examiner | | Immediate Causi disease or condit resulting in death | e (Final tion | a | Cemi | cal | Como | | | | Onset a | nd Death | |
| | | ě | | | | A DUB TO | oras a conseq | uence of): | | | | B å | | |
| | cate be executed physician and site burial-transit | edical Examiner | Sequentially list of it any, leading to cause. Enter Uni | conditions, immediate | Due to (or as a consequence of): | | | | | | | | | |
| 68760, | ifficate be specul g physician and as the burial-tra- | Cal | Cause (Disease of that initiated ever resulting in death | or injury atts | C | Due to (or as a consequence of): | | | | | | | | |
| Box 6 | nding pt | | TOGORATO ET OCCUT | L | d | | | | | | | | | |
| | desth cert e attandin rd for usa | Ca | Part II. Other slor | nificant conditions | onditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | obacco use contr | ibute to the cau | se of death? | |
| P.O. | requires that the death certifi seen signed by the attending hould be detached for use at | by Physician/W | | | | | | | | | | Probably | | |
| Records, | | Completed b | | | | | | | | 24a. Was perfo | an autopsy med? | 24b. Were autop available pr completion of death? | ior to | |
| Be | sician: The law is certificate has bifrector, page 2 si | Ĕ | | | | | | | | 101 | (es 20/0 | 1 Yes | alta No | |
| VItal | Ifficat tor, p | Be C | 25. Was case refe | erred to medical | | | | | 26. Place of Dec | ath (Check only o | | | | |
| > | Physician: this certific ral director, | 10 | examiner? | No. | Hospital: 1 🔲 | npatient 2 | ER/Outpatien | 3 DOA | Whor | | | (Specify) | | |
| lon of | Attending Physician: ir desth. ector: After this certific by the funeral director, | | 27. Manper of Death 1 Natural 2 Accident 3 Suicide 4 Homicide | | | of Injury th, Day Year) | 28b. Time of Injury | | Survival Nursing Home 5 Residence 6 Other (Specify) | | | | | |
| Division | X22 C | Certification: | | | be on Disserting Athense to the state of the | | | | | | | per or Rural Route Number, | | |
| | To the Hospital or within 24 hours elter To the Funeral Discompletaly filled in | edical C | 29a. Certifier (Check only one) | 12 Certifying F | aminer: On the ba | best of my knows of examination | owledge, death ation and/or inv | occurred at the restigation, in my | time, date and place opinion, death occu | , and due to the orred at the time, | cause(s) and mand date and place, an | ner as stated. d due to the cau | se(s) | |
| | To the Fo the | E | 29b. Signature an | nd title of certifier | n to a color | | | 29c. Lice | nse number | | 29d. Date signed | Month, Day, Yes | r) | |
| | - 2 - 0 | | D D | Way | 9 | MI | | D | 31464 | | 1/27/ | 00 | | |
| | 2 | | 30. Name and add | dress of person wh | 11284 | e of death (Ite | m 23a) (Type, | Print) | ft Finte | 308 | Ball | m1 21 | 2 ()4 | |
| | Sta | te | 31. Date filed (Mo | | 32. R | egistrar's Sign | | , | 4 1100 | | | - 113 -11 | | |
| | Registr | ar | IVVI | 2 8 2000 | K. | | La - | / | | | | | | |

ORIGINAL

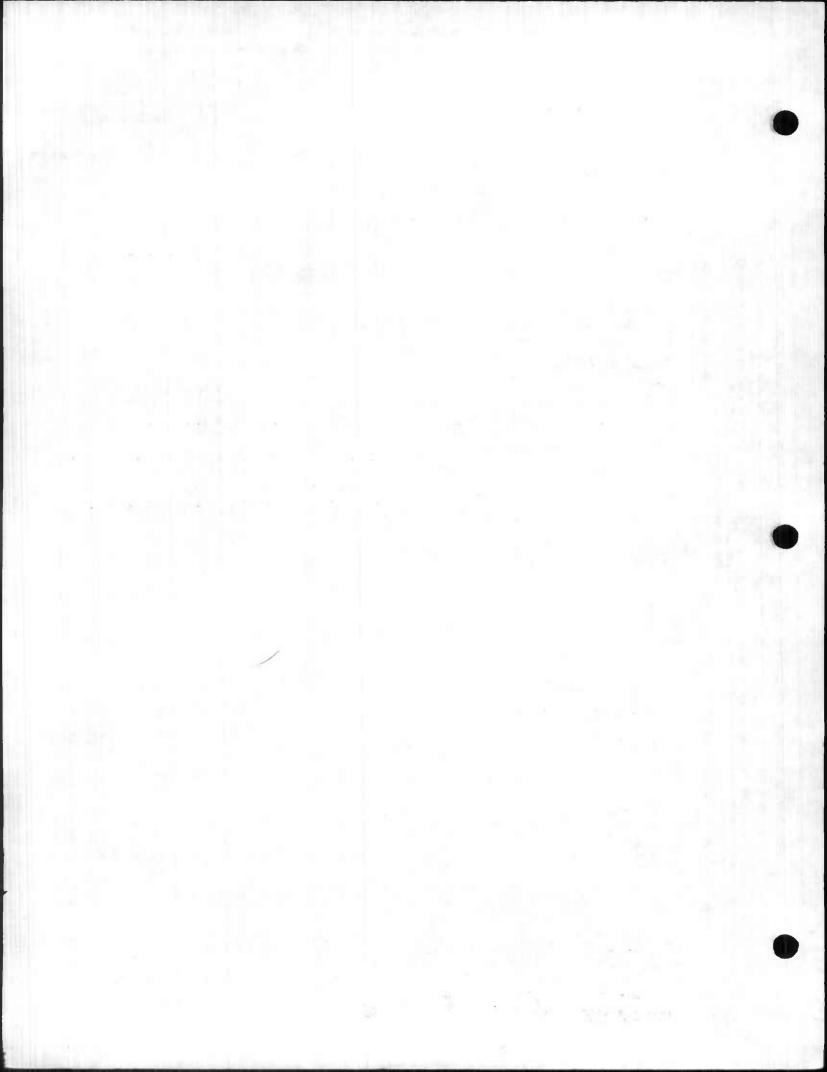


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene-Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 115 AM 25 2000 - Month **Physician** Dorothy R. Ginsburg January /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Union Memorial Hospital Baltimore N/A 8. Date of Birth Month, Day, Year) Feb 29, 1912 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)
 M.d. 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 1□M 24□F Yrs. 219-38-9766 87 Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show N/A 1 N Yes 2 No Baltimore Md. Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 2305 Crest Road 21209 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11 Marital Status Pages 1 and 2 should be filed within 72 hours after next of Health and Mental Hygiene. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0020 8 1 ☐ Yes 2 ☐No Specify. Specify: White ğ Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 4 School Teacher City Public School 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 89 Louis Rosen Belle Kurtz 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) * nt of Health a if Item 27 is or other tra-5604 Wexford Rd., Balto., Md. 21209 James L. Ginsburg Son 20b. Place of Disposition (Nama of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Department of Important: If any injury or Balto-Wash.Crematory 1-28-00 Laurel, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licental 22. Name and Address of Facility Bradley-Ashton-Matthews Funeral Home, Inc 2134 Willow Spring Rd Balto Md 21222

23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, interval Between Onset and Death Physician Preumouia 8 dan /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Dua to (or as a consequance of): Examiner or Attending Physicien: The law requires that the death certificate be executed the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical Due to (or as a consequence of) 88 for use Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? cardionygrafle 1 Yes 2 No 3 Probably 4 Unknown ate has been signed page 2 should be de Records, g 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy 1 Yes 2 BNo 1 ☐ Yes 2 ☐ No certificate Division of Vital funeral director. Be 25. Was case referred to medical 26. Piace of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Matural 5 Pending 24 hours after death, Funeral Director: A investigation 1 Yes 2 No 2 Accident 6 Could not be detarmined 3 Suicide 28e. Place of Injury - At home, farm, atreet, factory, office building, etc. (Specify) 28t. Location (Street and Number or Rural Routa Number, City or Town, State) filled in by 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier completely (Check only one) within 2 To the ŝ 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number mich MO 2000 30. Name and address of person who comp ne of death (Item 23a) (Type, Print) timore MD #631 37r31. Data filed (Worlth, Day, Year) 32. Registrar's Signature State Registrar

DHMH 16 Ray 6/95

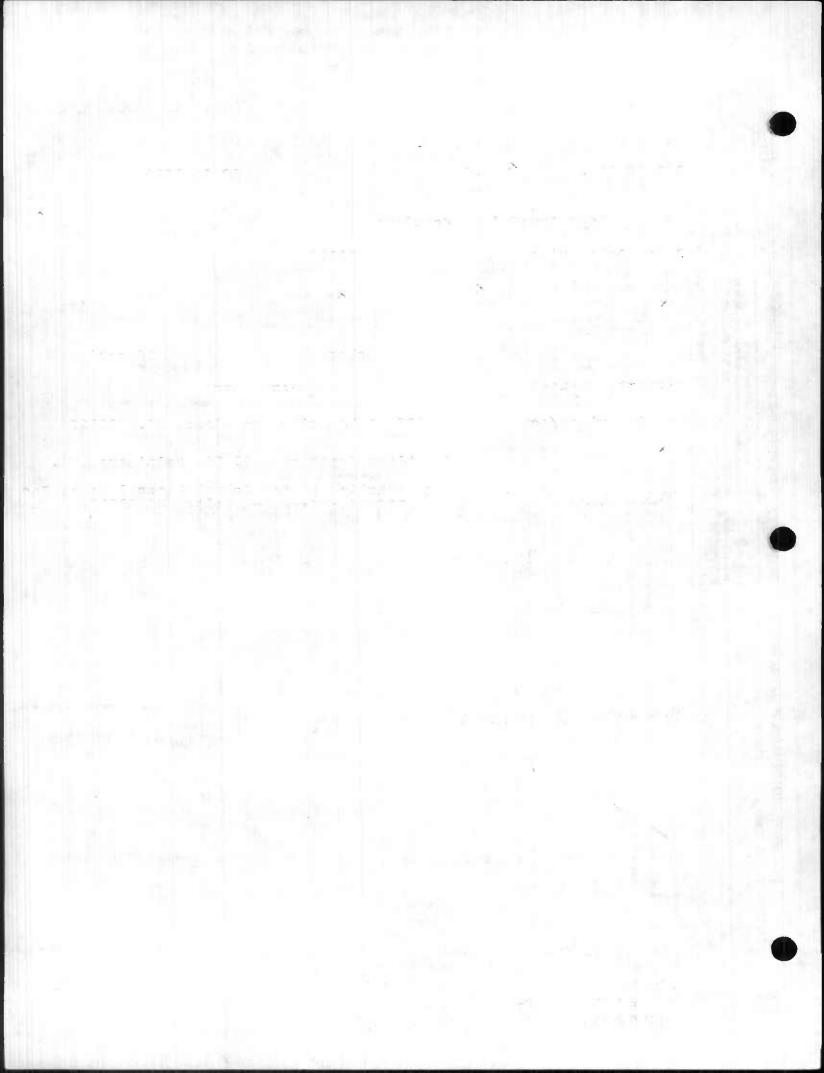


Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Yea **Physician** MA OHII 0005 Julia H Grimas Jan /Medical 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Catonsville Baltimore 5. Sociel Security Number 6. 'enter (are If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Months 1 M 2 F Yrs. 153-18-1200 83 Director 29 Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or hama 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Directo Anne Arundel Md Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2250 Lake Drive 21122 USA Funeral death Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? 11. Meritel Stetus permit. Pages 1 and 2 should be filled within 72 hours after c Department of Health and Mental Hygiene. Important: If New 27 Ia marked other than "natural" or income. Bleck, White, etc. 1 Yes 2 No If Yes, Give Yeer or Detes: 1 Never Married 2 Merried 1 Yes 2 No Specify: Specify þ 3 Widowed 4 □ Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Teacher Education 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be Herbert Hanson Mary Moore 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) Dennis Grimes/son 2250 Lake Drive, Pasadena, Md. 21122 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ■ Buriel 2 □ Cremetion 3 □ Removel from Stete 4 ☐ Donelion 5 ☐ Other (Specify) Crestlawn Cemetery 01 26 Baltimore, Md. 21. Signature of Funeral Service Licen 22. Name end Address of Fecility Sterling Ashton Schwab Funeral Home, Inc 23a. Pert1. Enter the disease are complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heert failure. Line or ly one cause on each line. Md 21228 Approximate Interval Between Onset and Deeth Physician /Medical Immediate Cause (Final disease or condition resulting in death) · Proumonia Examiner Due to (or as a consequence of): Examiner physician and s the buriel-transit the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medicai Due to (or as a consequence of): Pert fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert f. 23h. Did tobacco use contribute to the cause of death? P.O. 1 Yes 2 No 3 Probably 4 Unknown Parkinsons discose þ Division of Vital Records. The law requires 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed page 2 has 1 Yes 2 No 1 Yes or Attending Physician: Be 25. Wes case reterred to medical exeminer? 26. Place of Deeth (Check only one) Hospitel: 1□ Yes 2☑ No Other:

Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Menner of Death 28a. Dete of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Affer 1 Natural 5 Pending n 24 hours after death.

Ne Funeral Director: Alphetely filled in by the fu death. investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, 1erm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. edicai 29a. Certifie To the Hosp within 24 ho To the Fune completely fi (Check only one) 29b. Signature end title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) 2000 2 mao Muy 30. Name and address of person who completed cause of death (frem 23a) (Type, Print) Ш Maiden choice Ln Catonsville MD Mula M Carpenter 31. Date filed (Month, Day, Year) 32. Registrer's Signeture State Registrar 14N 3 8 5000



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death JANUARY 24, 2000 11:15 am CORNELIUS M. GILMORE JR. 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth GENESIS ELDERCARE AT HOMEWOOD BALTIMORE 5. Sociei Security Number 6. Sex, 1 ☐ M 2 ☐ F If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. lest birthdey) Birthplece (State or Foreign Country) Days Yrs. 72 MD. 217-20-1731 Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1☐¥es 2☐No N/A BALTIMORE 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 527 CUMBERLAND ST. 21217 USA Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) Rece - American Indien, Bleck, White, etc. 11. Maritel Status 1 Never Married 2 Merried 1 ☐ Yes 2 ☐ No Specify: Specify: BLACK 3 ☐ Widowed 4 ☑ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use ratired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) -12--0-TRUCK DRIVER TRANSPORTATION 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) CORNELIUS M. GILMORE SR. GLADYS HAYES 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 527 CUMBERLAND ST. BALTIMORE, MARYLAND 21217 LEON GILMORE (BROTHER) 20e. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 1 Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) GARRISON FOREST VETERANS 2-1-2000 OWINGS MILLS, MARYLAND 22. Name end Address of Fecility 21. Signature of Funeral Service Licarses PHILLIPS FUNERAL HOME, P.A. HBner 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Pirt1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset end Deeth Immediate Cause (Final Accident diseese or condition resulting in deeth) Due to (or es e consequence of) Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Lest Due to (or es e consequence of) Due to (or es e consequence of): Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were sutopsy findings aveileble prior to 24a. Wes en eutopsy performed? completion of cause of deeth? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical exeminer?

Physiclan /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

"natural", or items 23a or 28a-f show solical Examiner owest be notified at

The Medical

Pages 1 end 2 should be filed within nent of Heaith end Mental Hygiene. Int: If Item 27 is merked other than ' Irry or other traumatic event, tra Ma

permit. Page Depertment of Important: If any injury or

Funeral Director

Completed by

Be

death with the Maryland

filed within 72 hours efter

Baltimore, Maryland 21215-0020

the buriel-transit director, page 2 should

requires that the death certificate be executed P.O. Box 68760, Records, The law Division of Vital or Attending Physician: After s efter death. in by t

Physician/Medical Examiner à Be Completed

To the Hospital within 24 hours e Hospital

Certification: To 27. Mennef of Deeth

Medical

State Registrar

1 Yes 2 No

1 Naturel

2 Accident

3 ☐ Suicide

4 Homicide

(Check only one)

29b. Signeture end title of certifier

SALUITIND 1600 W. MOUNT ROYAL AVE BALTO 21217

32. Registrer's Signature

Dete of Injury (Month, Dev Year)

1 Dinpatient 2 ER/Outpatient 3 DOA

28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28b. Time of

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end menner as stated.

| Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, end due to the cause(s) end manner stated.

1 ☐ Yes 2 ☐ No

29c. License number 37

26. Piece of Deeth (Check only one)

Other: 4 Nursing Home 5 Residence 8 Other (Specify)

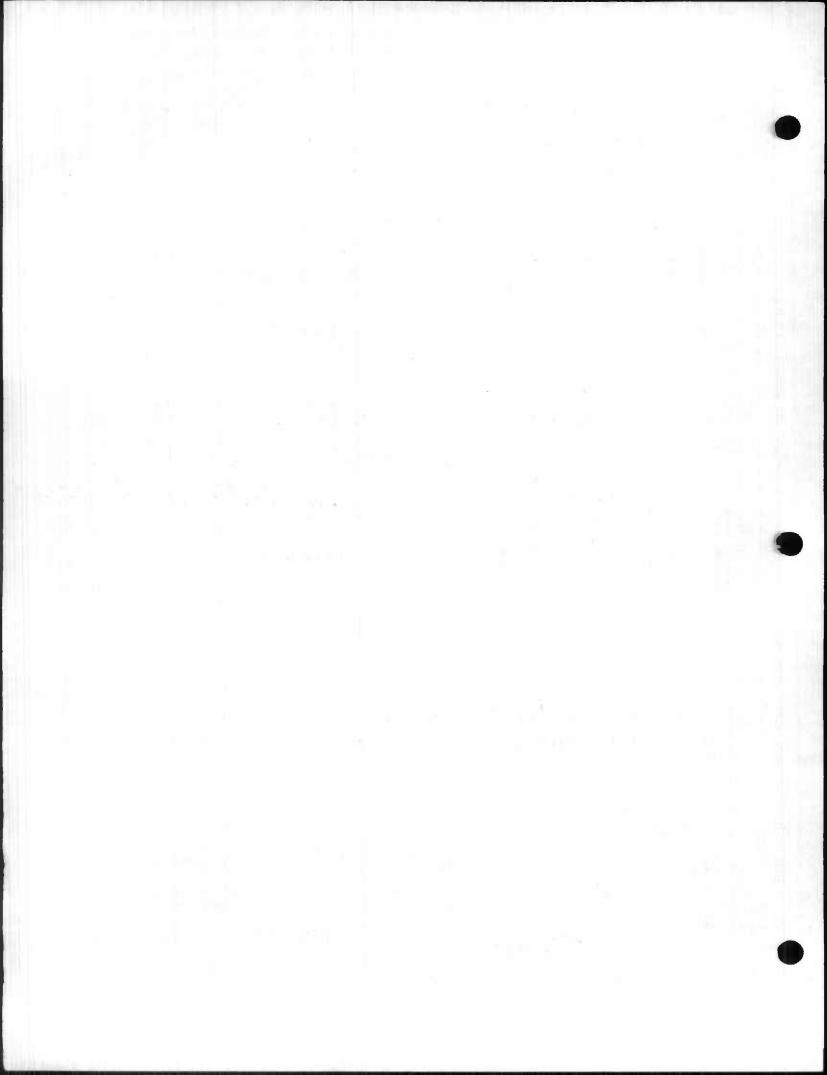
28d. Describe how injury occurred

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29d. Dete signed (Month, Dey, Year)

5 Pending investigation

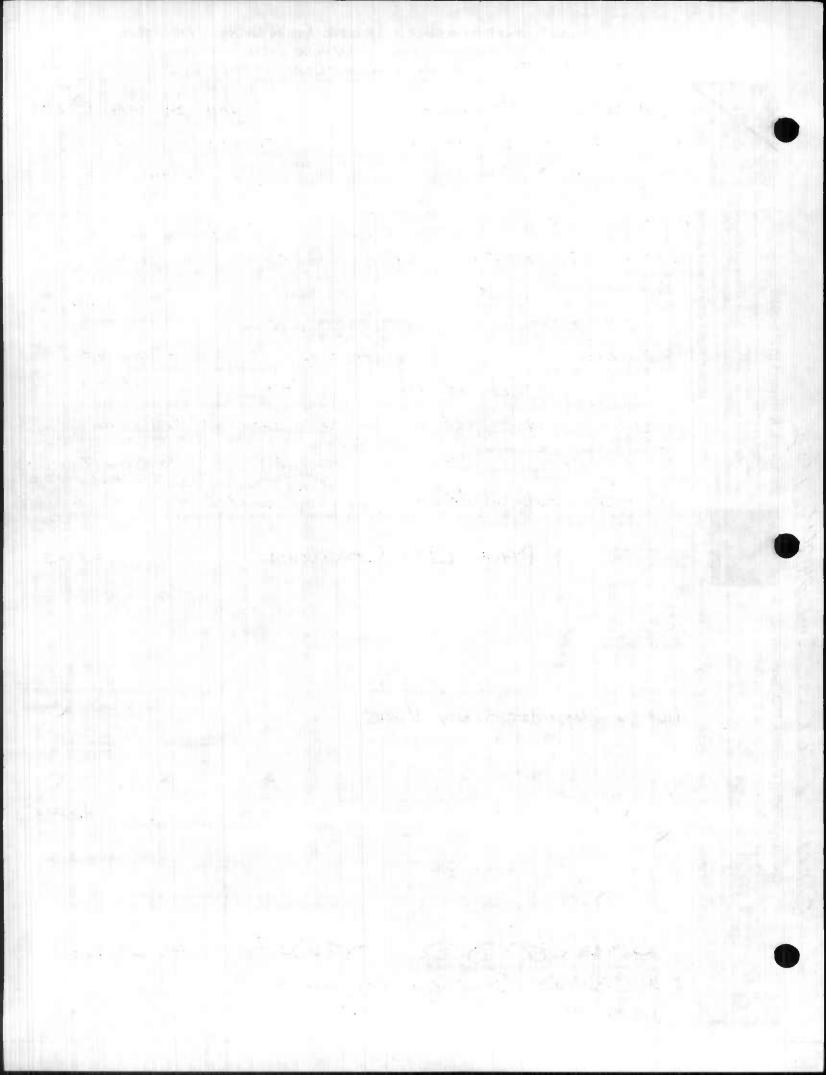
6 Could not be determined



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State of Maryland / Department of Health and Mental Hygiene

| | AMEND#7&8 PER F.H. 1. Decedent's Name (First, Middle, Last | | .A. Certificate | | 2. Date of Death | 3. No. | 3. Time of Dear | | |
|---|--|---|--|--|---|----------------------------------|--|--|--|
| Physician | CHADIES | HANKIN | 1< | | Month JAN | | 000 130 PM | | |
| /Medical | 4a Facility Nama (If not institution, giva | street and number) | / 3 | 4b. City, Town, or Loc | | 4c. County of | | | |
| Examiner | T | 1 1 | 0.00 | BALTI | 1105 | | 1110 | | |
| | | | PICE last birthday) If Undar 1 | DALTTH 1 Yaar If Undar 24 Hrs. | | 1020 T | O Bidhologo (State of For | | |
| Funeral Director | | X 7. Age (In yrs. 60 € | 9 Yrs. Months | Days Hours Min. | 8. Date of Birth (Month, Day,) DEC, 25 | (ear) 960 | 9. Birthplaca (Stata or For Country) MARVLAT | | |
| | Usual Rasidence of Decedent | 10- 0 | Tona | | | | | | |
| arylar show | 10a. Stata 10b. County | 10c. Cit | y, Town or Location | / | 1 .1 | | 10d. Insida City Lir 1∕S Yas 2 □ | | |
| tha Mary 28e-f sh notified | 10e, Street and Number | IA | 10f. Zip 0 | LTTHORE (| 174 | . Citizan of W | hat Country? | | |
| first death with the Maryland frems 23s or 28s-f show first must be notified at Funeral Director | 2112 2111 60 | DA # 20 A / 7 | | 21223 | ά / 103 | | | | |
| leath me 23 | 2102 W. SA | 12. Was Decedent Ever in U | | ant of Hispanic Origin? (Spec fy Cuban, Mexicen, Puerto R | city Yes or No- | 14. Race | SA - American Indian, | | |
| 1 | | Armed Forcas? 1 ☐ Yas 2 No If Yas, Giva Year or Dates: | If Yas, speci | | licen, etc.) | Black Specify: | , Whita, atc. | | |
| 72 hours at natural', or | 15. Decedant's Edu | | 16a. Decedent's Usual | Occupation | 16 | Sb. Kind of Bus | sinass/Industry | | |
| led within 72 horygiana. Per than "natural, the Medella | (Specify only highast grad | le complated) | (Giva kind of work lifa. DO NOT use | Occupation k done during most of working a ratired) | vorking | | | | |
| d with | 12 HIGRADE | Collega (1-4or 5+) | BA | KER | 6 | APITO | L CAKE CO | | |
| be filed of other event, I | 17. Fathar's Nama (First, Middla, Last) | | | 18. Mothar's Nama | | | | | |
| D = D = m | | HAWKINS | SP. | JANIE | | | BOVA | | |
| d 2 should th and Mer 7 is marke traumatic | 19e. Informant's Neme/Raletionship (T) | | 1 | (Straat and Number or Rural | | City or Town. 5 | Stata. Zip Coda) | | |
| nd 2 salth ar 27 is | ESTELLE HOLLOW | | | | | | | | |
| is 1 and 1 Haali item 2 other | 20a. Mathod of Disposition | / 20b. P | Place of Disposition (Nam. | SARATOGA | Date 20 | c. Location - 0 | City or Town, Stete | | |
| o = o | Burial 2 Cramation 3 F | Ramoval from State | cematary, cramatory or other | her place) | | | | | |
| artmer ortant: injury | 4 ☐ Donation 5 ☐ Othar (Specify) | , 141 | T, ZION CE | METERY P2. Addrass of Facility BRO | -02-00 L | ANSO | DUNE, MARYL | | |
| epar epar npor ny in | 21. Signatura of Funaral Sarvice Licans | aa N | 1. JOSE | Addrass of Facility BRO | WN JA | P. FUL | ERAL HOM | | |
| 20549 | Latert | N.U.lk. | 2141 | N. FULTON |) AVE U | BAY TIM | ORE, 140.21: | | |
| • | 23a. Part1. Enter the diseese, or comp shock, or haart feilura. List only o | ications that causad the deat | h. Do not antar tha mode | of dying, such as cardiac or | raspiratory aras | il, | Approximete Interval Between | | |
| Physician | Shock, of haart fellura. List only o | na causa on aach ina. | | | | | Onsat and Deatl | | |
| /Medical | Immediate Cause (Finel | RENAL C | THE CA | 201-114 | | | 6 MOS | | |
| Examiner | disaasa or condition rasulting in daath) | | | RCINOMA | | | 01905 | | |
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| buring buring | Causa, Entar Undarlying Cause (Disease or Injury | C | | | | | | | |
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| (S) (S) (S) | L. | d | | | | | | | |
| き 元文 男 | | | | | | | | | |
| y ma de | Pert il. Other significant conditions con | ntributing to death but not res | ulting in the underlying ca | iusa givan In Part I. | 23b. Did tob | acco use con | tribute to the cause of de | | |
| nat th | HUMAN LYMUN | DEFICIENCY | VIRUS | | 1 Yes | 2 □ No | 3 Probably Wunki | | |
| signed d be del | 1701 1710 101111070 | ober 10 12.007 | 0 (1-2) | · | | | | | |
| been s should should | | | | | 24a. Was an perform | | 24b. Wara eutopsy findin avellable prior to | | |
| has by go 2 st | | | | | | | complation of cause of death? | | |
| The hare had page | | | | | 1 ☐ Yas | ≥Ø No | 1 ☐ Yas 2 No | | |
| delan: The certificate rector, pay | 25. Wes cesa rafarrad to medical | | | 26. Placa of Death | (Check only ona |) | | | |
| | examinar? | Hospital: | ER/Outpatient 3 DO/ | Other | | | (Snacity) Les NC | | |
| Physical distriction of T. T. | 27. Menner of Deeth | 28a. Data of Injury | 28b. Tima of 28 | | 8d. Dascribe hov | | 1110 | | |
| Ather fune | 1 Natural 5 Panding investigation | (Month, Day Year) | Injury | Work? 1 ☐ Yes 2 ☐ No | | | | | |
| Attending r death. sctor: Aha by the furn iffication | 3 Suicida 6 Could not be | 28a. Place of Injury - At he | | | 8f Location (Stre | eat and Numba | or or Rural Route Number, | | |
| tal or Attending P rs after death, al Director: Attent led in by the funer Certification: | 4 Homicida datarmined | building, atc. (Specif | | - Onice | City or Town, | Stata) | | | |
| the HOSpital or Atternion 24 hours after dea the Funeral Director Tiptensy-liked in by the Aedical Certifice | 29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami | sician: To the best of my kno ner: On the basis of axamina | wledge, deeth occurred e tion and/or invastigetion, | of the time, dete end piece, end in my opinion, daath occurre | nd due to tha cau d et tha tima, dat | usa(s) and mar a and place, a | nner es stated. nd dua to tha cause(s) | | |
| Med approx | | and menner steted. | 290 | Licansa number | 20 | d Date sloped | (Month, Day, Year) | | |
| A 48 7 | 29b. Signature and title of pertifier | 12- | 290. | - C 3 C 7 | | _ | | | |
| NY/I/ | NOW/S W | L/ 8 M | D | 2632+ | | AN. 2 | 4,2000 | | |
| 111/1 | 30. Neme and address of purson who co | ompleted cause of deeth (Item | n 23e) (Type, Print) | | | | | | |
| V | 6114 C KUPFIRE | E, COLUM | BIA MD | 21045 | | | | | |
| State | 31. Data filad (Month, Day, Year) | 32. Registrar's Signa | dya Swacks | 1 | | | | | |
| Otate | | | | er. | | | | | |



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Year Month **Physician** BERITHA IRENE HOPKINS 27 2000 4c. County of Death JANUARY 2000 5:00 OM /Médical 4a Facility Name (If not institution, giva street and number) 4b. City. Town, or Location of Death Examiner Saint Joseph Medical Center Towson Baltimore # Under 1 Year | If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 10M 20F Yrs Director 218-28-3119 NOV 6,1911 MD Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director 280-7 MD BATTMORE LVTHERVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? b U.S.A 14. Race - American Indian, ROAD 21093 14 THORN HILL Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 11 Marital Status Black, White, etc. 1 Never Marriad 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give 8 altimore, Maryland 21215-0020 1 Yes 2 No Specify. Specify. à 3 ☐ Widowed 4 ☐ Divorced Year or Dates WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) 12 HOMEMAKER DOMESTIC 17. Father's Name (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Sumeme) Be Pages 1 and 2 should be nent of Health and Mental la marked o raumatic eve 2 JAMES GRAHAM BLACK BERTHA IRENE MERRY MAN 19a. Informant's Nama/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rurat Route Number, City or Town, Stata, Zip Code) Department of Health in Important: If Item 27 It any injury or other tra EDWARD B. HOPKINS, SPOUSE THORN HILL RO. LUTTIERVILLE, MD. 21093 20a. Method of Disposition 20b. Place of Disposition (Name of Data 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) DULANEY VALLEY MEM. GONS! 2000 MUNIONIT 22. Name and Address of Facility EVANS FUNERAL CHAPEL 21. Signature of Funeral Service Licansee asort 21 2325 TORK PD. 7MON (U) is pel caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, as on each line. TIMONIUM MO 21093 23a. Part1 Entar tha disease, or coordinates shock, or heart failure. List only on Approximata Interval Between Onset and Death **Physician** /Medical Immediata Causa (Final ASPIRATION PNEUMONIA disease or condition resulting in death) Examiner Dua to (or as a consequence of) Examiner physician and s the burial-transit be executed Sequentially list conditions, if any, leading to immediate causa. Entar Underlying Cause (Disease or injury that initiated evants resulting in death) Last Dua to (or as a consequence of): Box 68760 Physician/Medicai Due to (or as a consequence of): P.O. Part If. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown signed be det Records, ð 24b. Wera autopsy lindings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed page 2 1 Yes 2 No 1 Yes 2 No certificate Vital Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certific 25. Was case refarred to medical Be 26. Place of Death (Check only one) Hospital: 1 Nnpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Rasidence 6 Othar (Specify) 1 Yes 2 No Certification: To Division of funeral 28a. Date of Injury (Month, Dey Year) 27. Mannar of Death 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 4 Homicide To the Hospital or A within 24 hours after To the Funeral Direcompletaly filled in b Certifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) edical 29a. Certifier and manner stated. 29b. Signature and fills of conflic 29c. License number 29d. Date signed (Month, Dey, Year) de-100

DHMH 16 Rev 6/95

State Registrar

31. Date filed (Month, Day, Year) JAN 2 8 ZUUU

LIM.

BOON P.

30. Nama and address of person who complated cause of death (Item 23a) (Type, Print)

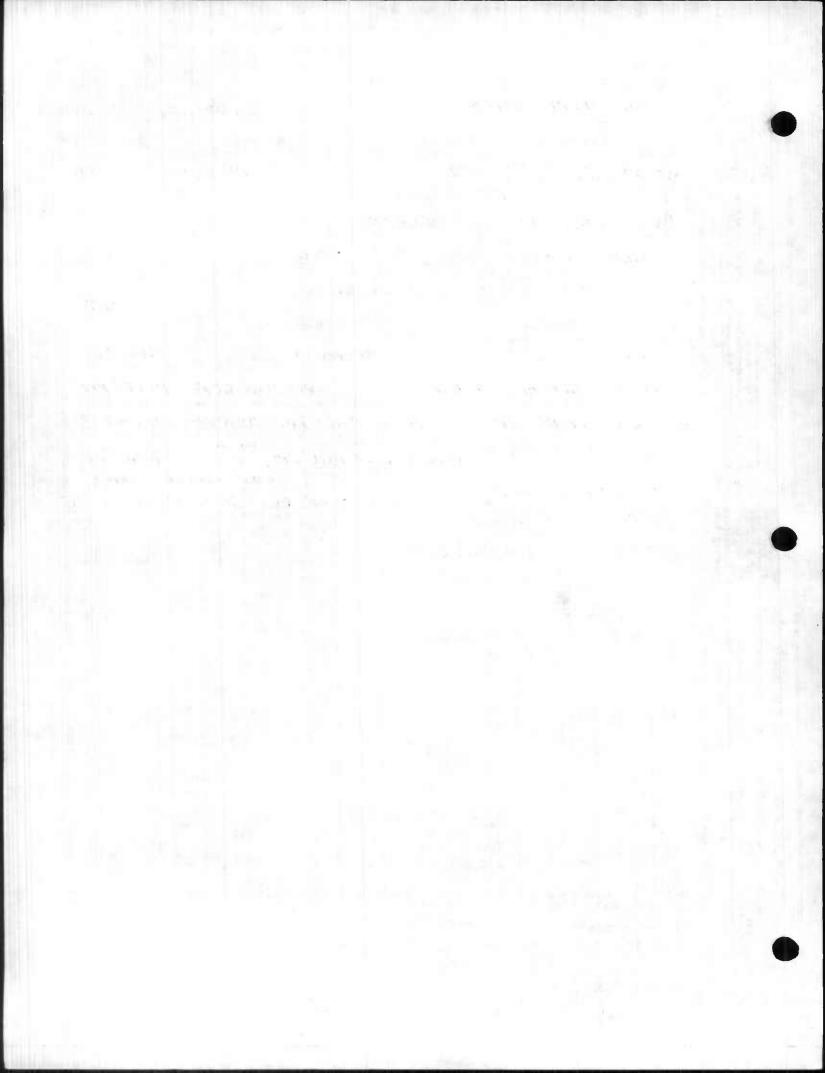
M. D. .

7601 OSLER DRIVE. 32. Regiştrar's Signature

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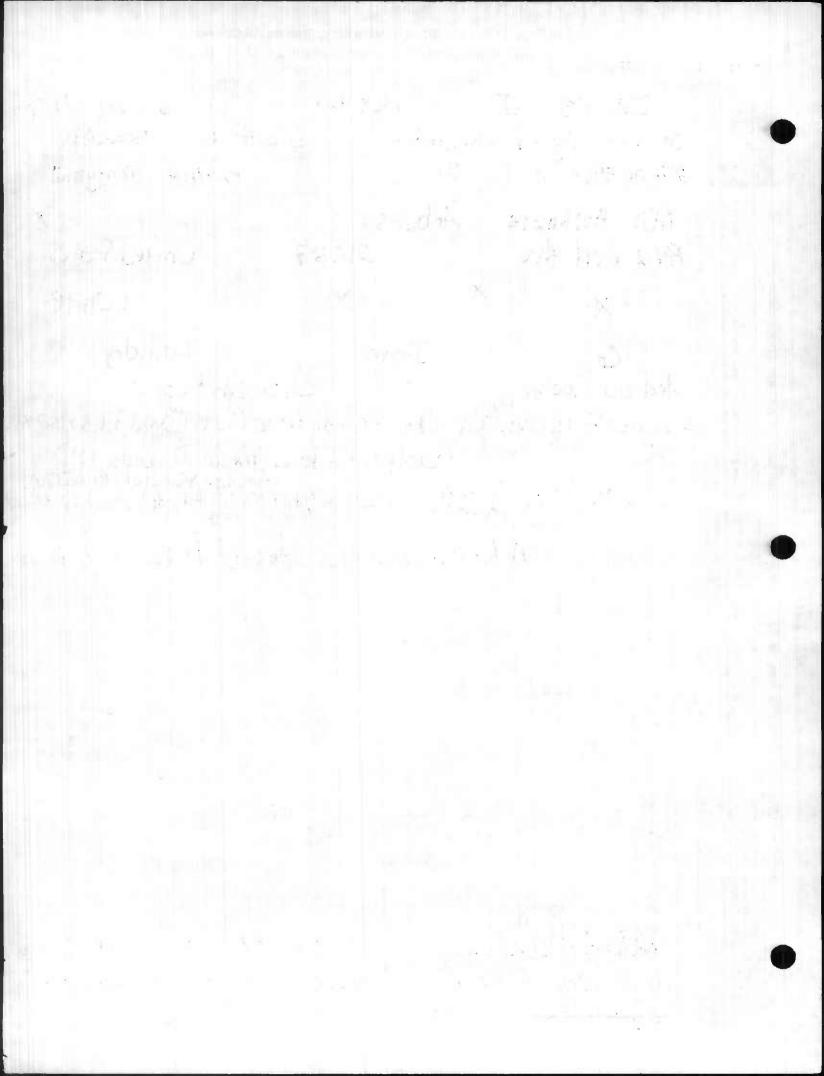
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Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene amend item 31 per DVR G779 1/28/00 yq Certificate of Death Reg. No. 3. Tima of Death 2. Date of Death 1. Decedent's Neme (First, Middle, Last) 728n HOEHN **Physician** a5 AME 2000 0 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4e Facility Neme (If not institution, give street and number) Examiner St. Agnes
5. Social Security Number Ellicott Cit Center HOWARD Rehab .+ If Under 1 Year If Under 24 Hrs. last birthday) 9. Birthplace (State or Foreign Months Deys Hours Min. 10 M 2 F 212-01-596 Mary Director Usual Residence of Decedent with the Maryland 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or flems 23s or 28s-f shor traumstic event, the Medical Examiner must be notified as Baltimore 1 Yes 2 No Director 10g. Citizen of Whet Country? 10f. Zip Code 2122 permit. Pages 1 and 2 should be filed within 72 hours after death in Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or frems 23s any Injury or other traumatic event. Funeral 0 12. Was Decedent Ever in U.S. Armed Forces?, 1 ☐ Yes 2 D No if Yes, Give Yeer or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race -American Indien. 11. Marital Status Black, White, etc. 1 ☐ Never Merried 1□ Yes 20 No 2 Merried Baltimore, Maryland 21215-0020 Specify: by 3 Widowed 4 Divorced Completed 16e. Dacedant's Usuel Occupation 18b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elamantery/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Fether's Neme (F st, Middle, Last) Be toenr Andrew 2 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Addrass (Street end Number or Rurel Route Number, Hoenn 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Burial 2 Cremetion 3 R 3 Removel from State 22. Name and Address of Facility Amoltone ature of Funeral Ser 21 Sin 201 Do not entar tha moda of dying, such as cardido or respirets to 23a. Pert1. Entar the disease, or complications that cards shock, or heart failure. List only ona causa on aech Approximate Intarval Between Onset end Death **Physician** /Medical Immediate Causa (Final disease or condition resulting in deeth) Examiner Dua to (or es a consequance of) Examiner Sequantially list conditions, if eny, leading to Immadieta cause. Enter Underlying Causa (Disaase or Injury that initiated evants rasulting in deeth) Lest Due to (or es e consaguance of): Box 68760 Physician/Medical the Due to (or es a consequence of): USB Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? been signed by the s should be deteched Division of Vital Records, P.O. 3 ☐ Frobably 4 ☐ Unknown 1 ☐ Yss 2 ☐ No þ 24b. Were eutopsy findings eveilable prior to completion of cause of death? Completed 24e. Wes en eutopsy pege 2 1 Yes 2 FINO 1 Yes 2 No certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this cartifica completely filled in by the funeral director, 25. Wes casa rafarred timedical exeminer? Be 26. Place of Phath (Check only one) Other: 4 ursing Home 5 Residence 8 Other (Specify) 1 Yes Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Manner of Death 28a. Deta of Injury (Month, Day Year) 28c. Injury et Work? 28d. Describe how Injury occurred 28b. Time of 1 Natural 5 Panding 1 Yas 2 No Invastigation 2 Accident 3 Sulcide 6 Could not be datarmined 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Plece of Injury - At homa, farm, streat, fectory, offica building, etc. (Specify) 4 Homicide edicai 1 Certifying Physician: To the bast of my knowledge, death occurred at the time, date and piece, and due to the causa(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) in manner stated. 29a. Cartifier 29d. Dele signed (Month, Day, Year) 29b. Signatufe and title of 29c. License number who completed causa of daeth (Item 23e) (Type, Print) Deb 31. Dete filed (Month, Day, Yeer) 32. Registrar's Signeture
JAN 2 8 2000 State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 4b. City, Town, or Location of Death 4c. County of Death 1:54 PM Earl Joseph Hazelwood /Medical 4a Facility Name (If not institution, give street and number) Examiner Union Memorial Hospital Baltimore If Under 1 Year if Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 05-02-35 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (Stata or Foraign **Funeral** Country) 1□M 2□F Months Days Hours Yrs 220-30-2644 64 Director Usual Residence of Decedent the Marylenc show 10a State 10b Counts 10c. City. Town or Location 10d. inside City Limits 7 is marked other than "natural", or items 23s or 28s-f shov traumatic event, the Medical Exactions count be notified at 1 Yes 2 No Director MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 304 Eudowood Lane 21286 USA death Funera 13. Was Decadent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 22 No 14. Raca - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after next of Health and Mental Hygiena. 1 Never Married 2 Married 1 ☐ Yes ZENo Specify: Specify: Black If Yes, Give Year or Dates: p 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work dona during most of working life. DO NOT usa retired) (Specify only highast grada complated) Etementary/Secondary (0-12) Coilege (1-4or 5+) 11th Grade Laborer various trades 18. Mother's Name (First, Middla, Maidan Surnama) 17 Father's Name (First, Middle | lest) Unknown Audrey Ragsdale 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 21286 19a. informant's Name/Relationship (Typa, Print) Hazelwood 304 Eudowood Avenue Baltimore, Maryland Mattie other 1 20a. Method of Disposition 20b. Placa of Disposition (Nema of camatary, cramatory or other place) 20c. Location - City or Town, State MD Wariai 2 Cremation 3 Removal from b Department of Important: If any injury or 01-29-2000 Randallstown, 4 ☐ Donation 5 ☐ Other (Specify) Kings Mem. Pk. Cem. Funeral Service Lice 22. Name and Address of Facility Baltimore, Maryland 21202 WM.C. March FH 1101 E. North Avenue caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, each line. in the disease, or completeent faiture. List only one Approximate Intervel Between Onset and Deeth **Physician** /Medical Immediate Cause (Finel monary Ihour disease or condition resulting in death) Examiner Due to (or as a consequence of) Examiner neumonia physician and the burial-tran Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequenca of) certificate be axecu Physician/Medical Due to (or as a consequenca of): Se USB (signed by the a 23b. Did tobacco use contribute to the ceuee of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 1 Yee 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? Completed page 2 s 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No certificate or Attending Physician: director 25. Was case referred to medical Be 26. Place of Death (Check only ona) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 1 Propatient 2 □ ER/Outpatient 3 □ DOA 2 this funeral 28a. Date of Injury (Month, Day Year) 28c. injury et Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: After 1 Natural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 8 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 T Homicide 24 hours a Hospital 29e. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completaly (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) AT2438946 2000 23. January 201 E. University Parkway 30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print) Union Memorial Hospital John E. Lewis Jr Baltimore MD 21218 31. Date filed (Month, Day, Year) 32. Registrar's Signature oaks State

Registrar

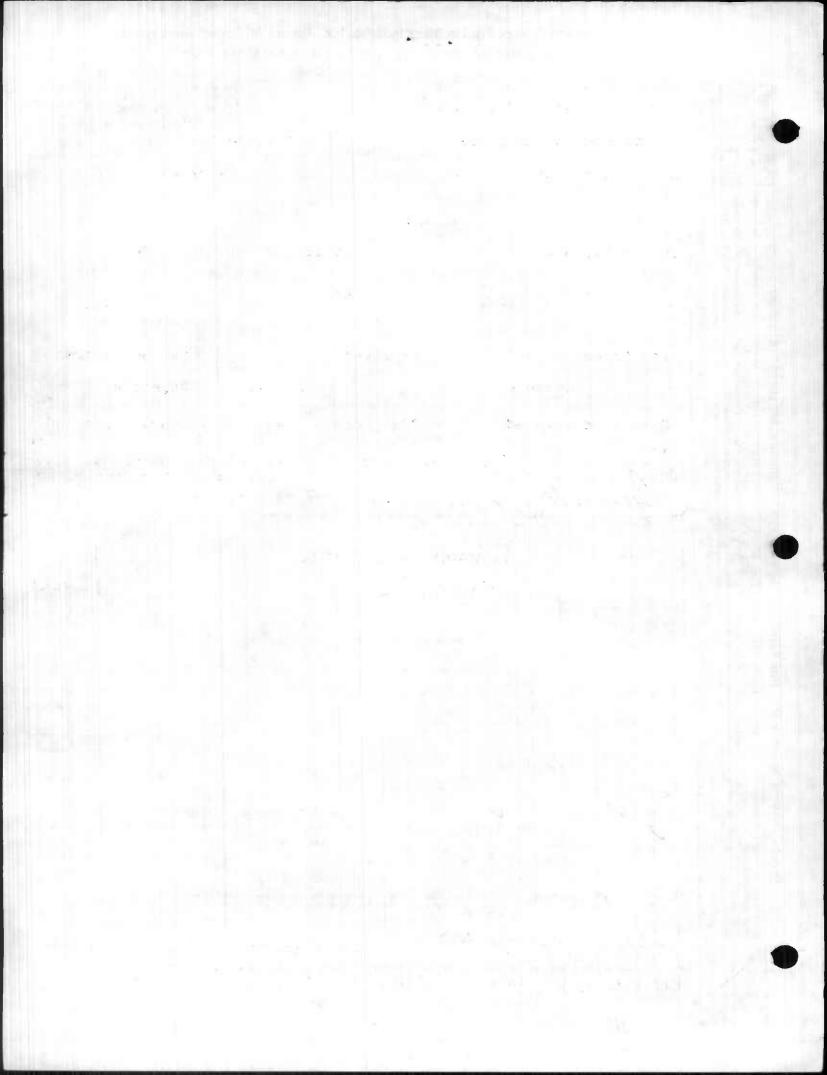
Baltimore, Maryland 21215-0020

Box 68760.

Division of Vital Records, P.O.

DHMH 16 Rev 6/95

JAN 2 8 2000



Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | | Items:10b,c,e,f per F.H G-779 1/28/2000 reb Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Tima of Deeth **Physician** Month 345m Helen Ha 2 2 2000 4c. County of Death /Medical 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth **Examiner** If Under 1 Year | if Under 24 Hrs. Howard Birthplece (State or Foreign Country) 5. Sociel Security Number 6 Sex 7. Age (In yrs. last birthdey) **Funeral** 1□M 2√F Deys Hours 214-47-7124 Usuel Residence of Decedent Yrs. Director 08-05 10e State 10b. County Baltimore Co. 10c. City, Town or Location Pikesville 10d. inside City Limits 28a-1 show traumatic event, the Medical Examiner must be notified at NA 'igfYes 2♥No Director MD 10e. Street end Number 10f. Zip Code 21208 10g. Citizen of Whet Country? ò ShamRock 510 238 USA 21206 Pages 1 and 2 should be filed within 72 hours efter death nent of Heelth and Mental Hygiene.
snt: If item 27 is marked other than "natural", or items 23. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 Yes 2 No If Yes, Give Yeer or Detes: 1 Never Married 2 Married 3altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: Black g 3 Widowed 4 □ Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) Coilege (1-4or 5+) DNEMPLOYED UNEM
18. Mother's Name (First, Middle, Melden Sumeme) 10 INEMPloyEd GRADE. NA 17. Fether's Name (First, Middle, Last) Be 2 John JONES JAIE < 19b. Meiling Address (Street end Number of Rural Route Number, City or Town, State, Zip Code) 19a, Informent's Neme/Relationship (Type, Print) Depertment of Heelth as Important: If item 27 is any injury or other tracents. Balto 3925 DERNICE DESSOM JUE 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition Dete 20c. Location - City or Town, State 1 Burial 2 □ Cremetion 3 □ Removel from State KANDALISTOWN, MD 4 ☐ Donetion 5 ☐ Other (Specify) 28/2000 of Funerel Service Licensee WEST WABASHAUE ! 1300 onlto 21215 23a. Part. Enter the disaese, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory should be not help the little only one cause on each line. Approximate Interval Batween Onset end Deeth Physician /Medical Immediata Ceuse (Finei STAGE LIVER DISEASE disease or condition resulting in deeth) Examiner MASSIVE ASCITES

Due to (or as e consequance of): Hospital or Attending Physicien: The law requires that the deeth certificate be executed
As hours afford death.
 Funeral Director: Affor this certificate has been signed by the ettending physician and
etely filled in by the funeral director, page 2 should be detached for use as the burle-transit Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Ceuse (Disaese or Injury that initiated events resulting in daeth) Last Encephalogathy Division of Vital Records, P.O. Box 68760, DATIC Physician/Medical Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23h. Did tobacco use contributs to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown à 24e. Wes en eutopsy performed? 24b. Ware autopsy findings evallable prior to completion of cause of death? Completed 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case refarred to medical examinar? Be 26. Placa of Death (Check only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 □ ER/Outpatient 3 □ DOA 27. Manner of Deeth 1 Waturai Medical Certification: 28b. Time of 28d. Dascribe how Injury occurred 28c. Injury et Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accidant 6 Could not be datarminad 3 Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, Steta) 28e. Piece of Injury - At home, ferm, streat, factory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di completely filled in 1x Certifying Physician: To the best of my knowledga, deeth occurred at the time, dete end plece, end dua to tha cause(s) end manner es steted.

2 Medical Examiner: On the basis of examination end/or invastigation, in my opinion, deeth occurred at the time, dete and plece, and due to the cause(s) end menner stated. 29a. Certifier 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) D0052560 Welsker Ayolin

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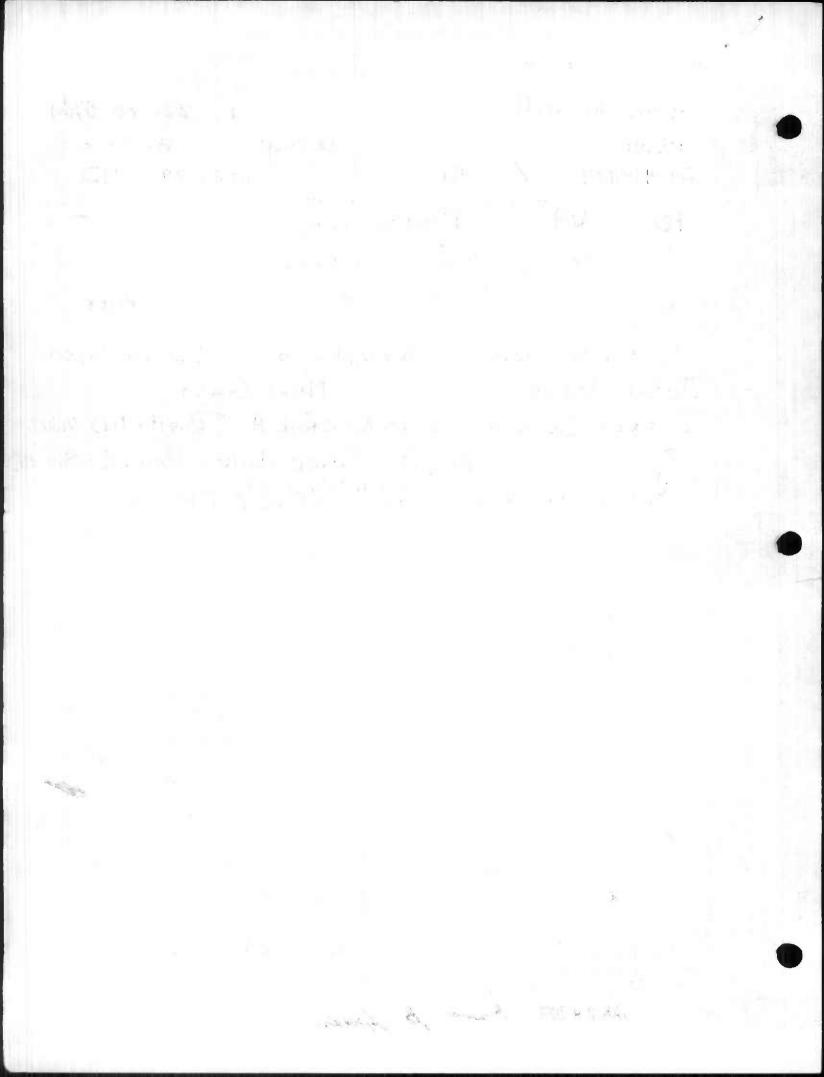
DHMH 16 Rev 6/95

State Registrar 30. Name end eddrass of person who complated cause of deeth (Itam 23a) (Type, Print)

JAN 2 8 2000

AYACEW

32. Registrer's Signature



State of Maryland / Department of Health and Mental Hygiene-Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dey Year **Physician** 15 JANVARY Florence Hairsine 23 2000 /Medical 4e Facility Name (II not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** n/a AGNES HOSPITAL BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months | Days | Hours | Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral 1 M 2 F 61 Maryland Director 218-58-8107 31 1938 Usual Residence of Decedent permit. Pages 1 end 2 should be filed within 72 hours after death with the Meryland Department of Health and Mentel Hygiene. Important: if Item 27 is marked other than "natural", or items 23s or 28s-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23e or 28a-f show traumatic svent, the Medical Examiner must be notified at Baltimore Md. n/a Yes 2 No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21230 USA 110 W. Randall Street Funeral 14. Race - American Indien, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Never Married 2 Married 1 ☐ Yes 2√7 No If Yes, Give Specify: white Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Nurses Aide Nursing Home 0 6 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First Middle Last) Be Naomi Catherine Burke Robert Glenn Hairsine 19a. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charmaine Scally (Friend) 600 Light Street Apt. 210 Baltimore, Md. 21230 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removel from State 4 Donation 5 Other (Specify) 6 2/02/2000 Baltimore, Md. Loudon Park Cemetery 21. Signeture of Funeral Service Licensee 22. Name end Address of Fecility McCully-Polyniak Funeral Home P.A. 23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate tnterval Between Onset and Deeth **Physician** /Medical Immediate Cause (Final . SGP815 20075 disease or condition resulting in death) Examiner Examiner shysician and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Last ANDEMIA Physician/Medical been signed by the a should be detached f Part II. Other signiffcant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 ☐ Probably 5€ Unknown INTE ITANAS INE DIVISION OF VITAI Records, g 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 MInpatient 2 □ ER/Outpatient 3 □ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Netural 5 Pending To the Hospital or Attandit within 24 hours after death. To the Funeral Director: All completely filled in by the fu 1 ☐ Yes 2 ☐ No Investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 15 Certifying Phyeician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) SIMEON OBENG M.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AVE. BALTIMORE. MD 21229 HOSP, 700, 900 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 2 8 2000 Seneva Registrar

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DHMH 16 Rev 6/95

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death 3. Time of Death JANUARY 26 2000 **Physician** MAUDE HALFPENNY 9:30 AM IRMA /Medical 4a Facility Nama (ff not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ANNE ARUNDEL CO. BROOKLYN PARK GENESIS ELDERCARE HAMMONDS LANE If Under 24 Hrs. Hours Min. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (Stata or Foraign Country) 8. Data of Birth (Month, Day, Year) **Funeral** 1 ■ M 2 1 F Months Days 96 215-03-9195 Director Aug. 10 1903 Maryland Usual Residence of Deceden the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. toside City Limits YOYes 2□ No Director Md. n/a Baltimore 288-7 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? b Name 23a 1723 Covington Street 21230 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 12. Was Decedent Ever in U.S. Armed Forcas? 14. Race - Amarican Indian. Black, Whita, atc 72 hours after 1 ☐ Yas 2 No If Yas, Giva 1 Never Married 2 Married "natural", or altimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: white à 3 Widowed 4 □ Divorced ... Year or Dates Completed 16a. Decedent's Usuel Occupation (Give kind of work dona during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry filed within 7 Hyglens. other than "n Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygien, Important if Isem 27 is marked other tha any injury or other traumatic Factory Worker Maryland Glass Co. 10 0 17. Father's Nama (First, Middle, Last) 18. Mothar's Name (First, Middle, Maiden Surname) Be Chelton Berman Ira Lena 19a. Informent's Name/Retetionship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) John J. Mildenberg (Son-in-law) 1723 Covington Street, Baltimore, Md. 21230 20a. Method of Disposition 20b. Place of Disposition (Nama of cematary, crematory or other place) 20c. Location - City or Town, Steta 17 Burial 2 ☐ Cremation 3 ☐ Removat from State 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Memorial Park 1/28/00 Glen Burnie, Md. 21. Signature of Funeral Service Licenses 22. Nama and Addrass of Facility McCully-Polyniak Funeral Home P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Apshock, or heart failura. List only one cause on each line. Approximate Intarval Batween Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) ration Examine (or as a consequence of): Examiner ementica physicien end the buriel-transit The lew requires that the deeth certificate be assouted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of) Box 68760. Physician/Medical Dua to (or as a consequence of) 980 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown Cardo Vascula Discus Records, 24b. Wara autopsy findings available prior to Completed 24a. Was an autopsy performed? completion of cause of death? 1 Yas 2 No 1 Yas 2 No Division of Vital 89 25. Was casa refarred to medicat 26. Place of Death (Check only one) Hospitat: Other: 4 Nursing Homa 5 Rasidence 8 Other (Specify) Certification: To 1 Yes 2 ZLMS 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Data of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? After or Attending 1 Natural 5 Pending deeth. 1 ☐ Yas 2 ☐ No n 24 hours after death. • Funerel Director: A bletsly filled in by the fu invastigation 2 Accident 6 Could not be detarmined 28e. Ptece of Injury - At homa, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 Cortifying Physician: To the best of my knowledge, deeth occurred at the time, date and placa, end due to the cause(s) and manner as stated.

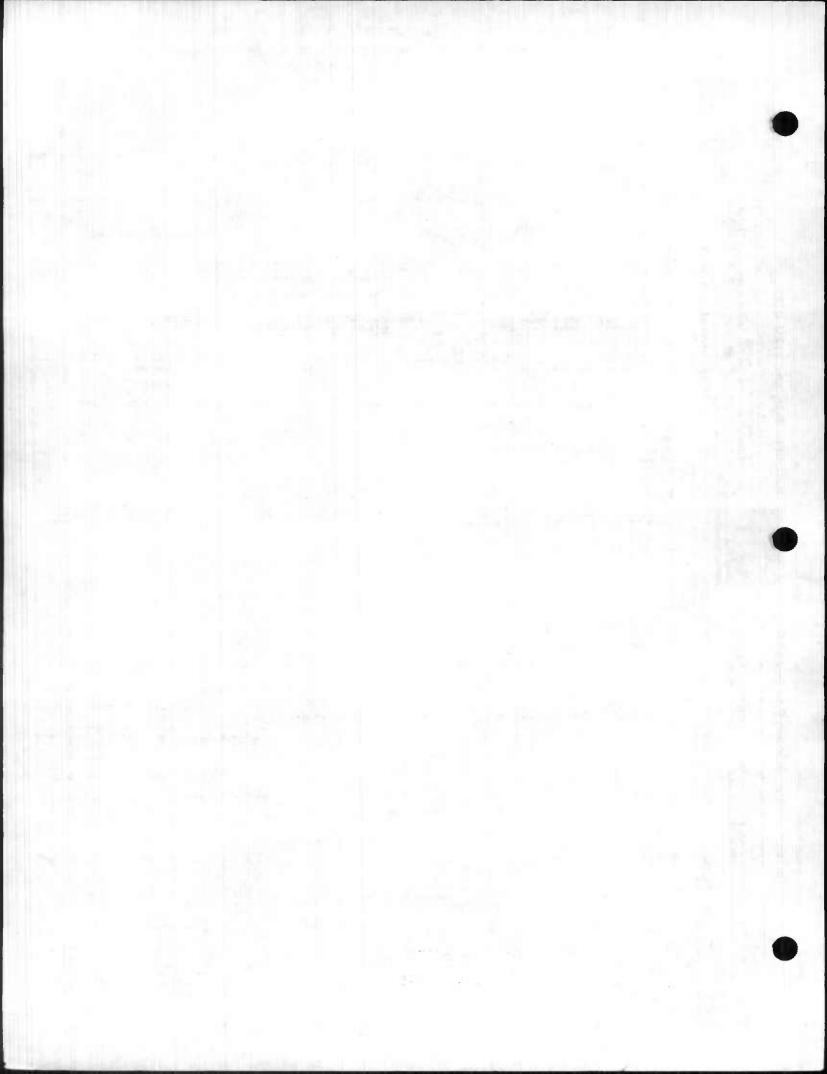
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie To the Hosp within 24 hor To the Fune completely fi (Check only one) 29c. License number 29d. Data signed (Month, Day, Year) Men 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1 hours and 31. Data filed (Month, Day, Year) 32. Registrar's Signatura State

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DHMH 16 Rev 6/95

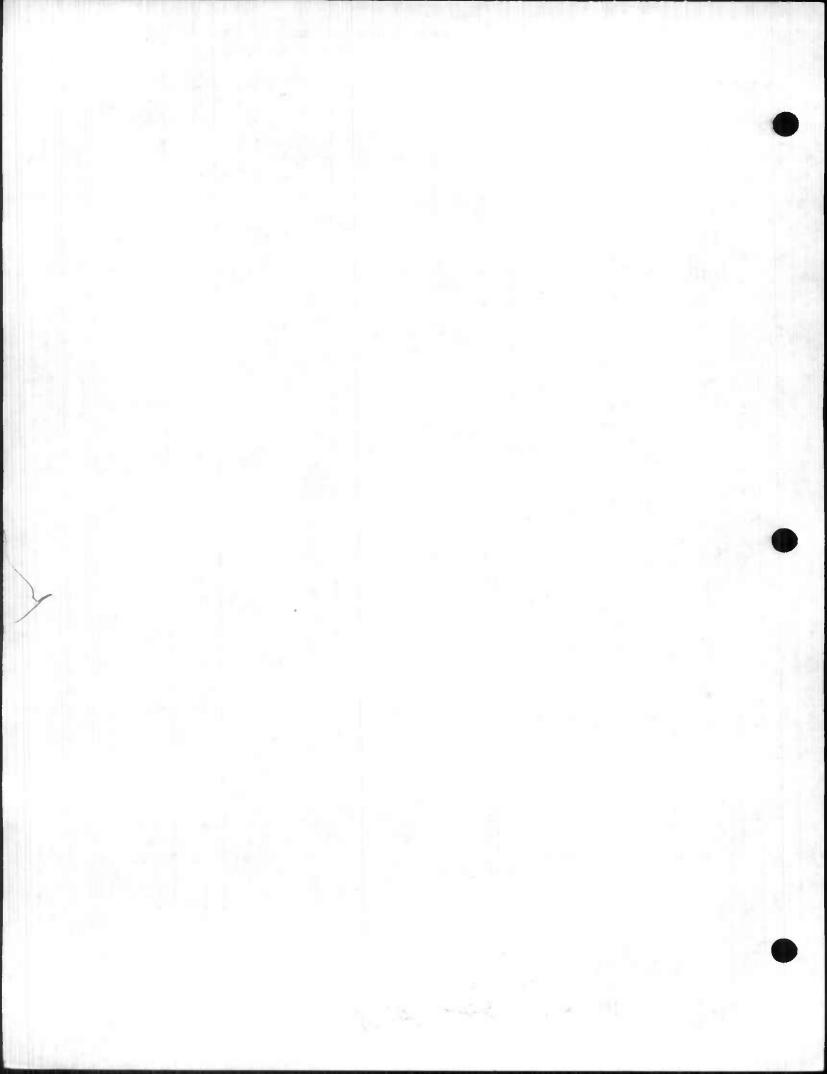
Registrar

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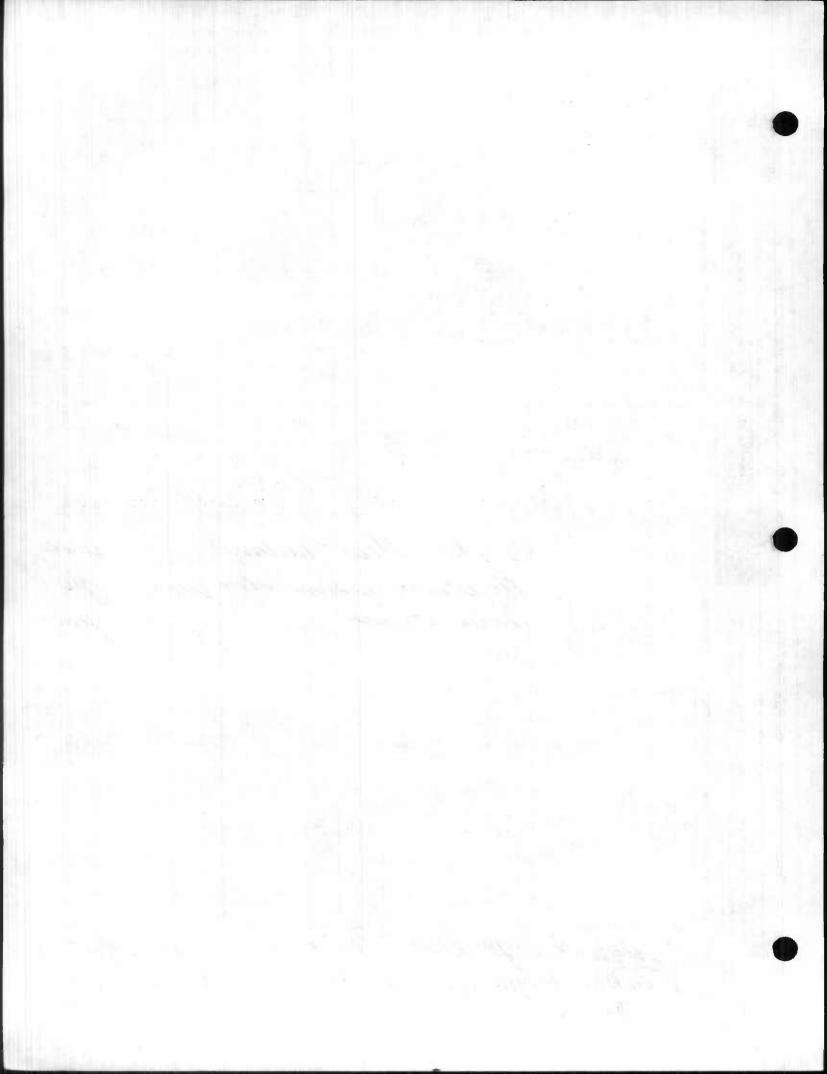


State of Maryland / Department of Health and Mental Hygiene 0 0 2022.

| | Ce | ertificate of Death | Reg, No. |
|---|---|---|---|
| | Decedent's Name (First, Middle, Last) | 2. Dete Mor | e of Deeth nth Day Yaar |
| Physician /Medical | Vernon | Hall 1 | 23 2000 11:05 a.m. |
| Examiner | 4a Facility Nema (If not institution, give street and number) 2504 Roslyn Avenue | 4b. City, Town, or Location of Baltimore | |
| Funeral Director | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthde) 89 - 03 - 3456 1 M 2 F 88 Yrs. | / If Under 1 Year If Under 24 Hrs. 8. Dete Months Deys Hours Min. 6 | e of Birth nth, Day, Year) -11-1911 9. Birthplace (State or Foreign Country) V a |
| 8 . | Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or to | ocetion | 10d. Inside City Limits |
| on the Maryland or 28a-f show a notified at Ofrector | Md N/A Baltin | | XXYes 2 No |
| E 5 E | 10e. Street end Number 2504 Roslyn Avenue | 10f. Zip Code 21216 | 10g. Citizen of Whet Country? U.S. A. |
| ar dea herma bescm cune | 11. Marital Stetus 1 Never Merried 2 Merried X Widowed 4 Divorced 12. Wes Decedent Ever in U,S. Armed Forces? Y Y Yes, 2 No 11 Yes, Give Year or Dates: | Was Decedent of Hispanic Origin? (Specify Yes If Yes, specify Cuban, Mexican, Puerto Rican, e | s or No- etc.) 14. Rece - American Indian, Bleck, White, etc. Specify: Black |
| 5-C | (Specify only highest grade completed) (Giv | edent's Usuel Occupation e kind of work done during most of working | 16b. Kind of Business/Industry |
| and 21215-0 be filed wittin 72 to halfylgers, of other than hedical. | Elementary/Secondary (0-12) College (1-4or 5+) life. | DO NOT use retired) | |
| Maryland 21215-0020 of 2 about be filed within 72 hours at the soft Marial Hydrox and the state of the than "natural", or traumetic event, the Medical Exam To Be Completed by F | 17. Fether's Neme (First, Middle, Last) Mack Hall | 18. Mother's Name (First, Minnie Mat | Middle, Meiden Sumeme) ilda Marshall |
| Maryls 62 should h and Mer 7 is marks treumatic | 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mel | ling Address (Street end Number or Rural Route | |
| , Maryle and 2 should sain and Wern Mary is marked set traumatic | Gary Hall - Son 250 | Dallas Court Baltimor | re. Md 21231 |
| Ore 1 to the state of the state | 20a. Method of Disposition 20b. Plece of Disposition | | |
| Pages sent of interest of inte | 112 Burial 2 Li Cremetion 3 Li Removel from Stete | | -00 Arbutus, Md |
| Baitimore, Marylan permit. Pages 1 and 2 should be Department of Health and Merital important. If item 27 is marked of any injury or other traumatic evuluas. To Be | | March F/H West 4300 Wabash Avenue | |
| | 23a. Pert1. Enter the disease, or complications that caused the death. Do not e shock, or heert feilure. List only one cause on each line. | nter the mode of dying, such as cardiac or respir- | Baltimore, Md 21215 Pelory arrest, Approximate Intervat Between |
| Box 68760, eath certificate be executed ethending physician and for use as the burial-transit clar/Medical Examiner | Immediate Cause (Finel disease or condition resulting in death) Due to (or as a consider of the conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consider of the conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | 2.000 | \c |
| Box sath cert for use is | d | | |
| o des | Pert It. Other significant conditions contributing to death but not resulting in the | underlying ceuse given in Pert I. 23 | Bb. Did tobacco uss contribute to the causs of death? |
| Is, P.O. Boy as that the death ce igned by the attend be detached for us, by Physician/ | Diabetes mellity | | 1 Yes 2 No 3 Probably 4 Unknown |
| /ital Records, P.O. Boy clan: The law requires that the death ce entificate has been signed by the attendi ector, page 2 should be detached for use Be Completed by Physician/ | Diabetes mellitus Gamme obstanchie la | ng discuse 24 | a. Wes an autopsy performed? 24b. Were eutopsy findings available prior to completion of cause of deeth? |
| The The Cor | | | 1 Yes 2 No 1 Yes 2 No |
| f Vital Recognitions of the National Property of the Computer | 25. Wes case referred to medicat examiner? | 26. Place of Deeth (Check | k only one) |
| ding Ph After thi funeral | 1 Yes 2 No Hospitel: 1 Inpatient 2 ER/Outpati 27. Manner of Death 1 Neturet 5 Pending 2 Accident investigation 1 Inpatient 2 ER/Outpati 28b. Dete of Injury (Month, Dey Year) 28b. Time Injury | of 28c. Injury et 28d. De | Residence 6 Other (Specify) |
| Divisio | 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, ferm, s building, etc. (Specify) | treet, fectory, office 28f. Loc City | cation (Street and Number or Rurel Route Number, y or Town, Stete) |
| Division of the Heaptal or Attanding Phywithin 24 hours after death. To the Funeral Director: After this completaly filled in by the funeral Medical Certification: 1 | 29a. Cartifier (Check only one) Certifying Physician: To the best of my knowledge, dee 2 Medical Examiner: On the basis of examination and/or and manner stelled. | | |
| Vithin to the complex of the complex | 29b. Signeture and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
| | * JMikdushi | 038046 | 1/27/00 |
| /~ | 30. Name and address of person who completed ceuse of deeth (Item 23e) (Type 1000 CauMe Aral Street | Beltimore, MD | 21201 |
| State Registrar | 31. Dete filed (Month) AN 28 2000 32. Registrer's Signature | 1. Some | |



| | | | | Certificat | e of | Death | | | Reg. No. | | |
|--|--|---|--|--|-----------------------|----------------------------|------------------------|---|------------------------------|---|--|
| Physician | Decedent's Neme (First, Middle, La NAOMI SHE | | TANET TOOM | | | | | 2. Dete of De Month | Dey | Year | 3. Time of Death |
| /Medical | 4a Facility Name (If not institution, gir | | HAMILTON | | | 6b. City. To | wn. or Lo | Januar | diameter . | 2000 | 4:25 P.M. |
| Examiner | 9 Thaxton Ct. | | ' | | | | oniu | | | timor | · o |
| Funeral | 5. Social Security Number 6. S | | Age (In yrs. last bir | thday) If Under Months | 1 Year Days | If Under Hours | 24 Hrs. Min. | 8. Dete of Birt | h Year) | | plece (State or Foreign |
| Director | 220-12-93/1 | 1□M 2XF | 93 | Yrs. | Days | Tiours | 101011. | 8. Dete of Birt (Month, Da Dec . 27 | , 1906 | Mar | y I and |
| Du A su | Usual Residence of Decedent 10a. State 10b. County | | 10c. City, Tow | n or Location | | | | | | 1 | Od. Inside City Limits |
| death with the Maryland ms 23s or 28s-f show r must be notified at ners! Director | Maryland Baltimo | ore | Tin | nonium | | | | | | | 1 ☐ Yes 2 No |
| or 28a-1 a be notified Director | 10e. Street and Number | | all plant | 10f. Zip | Code | | | | 10g. Citizen of \ | What Cour | ntry? |
| 23a or 28a-f ahow ust be notified at rai Director | 9 Thaxton Ct. | | | | 21 | L093 | | | U.S. | Α. | |
| or Itams | 11. Marital Stetus 1 Never Merried 2 Married 3 Widowed 4 Divorced | 12. Was Deceder Armed Forces 1 Yes 2 If Yes, Give A Year or Dates | s?] No | 13. Was Deced If Yes, spec | | | gin? (Spo i, Puerto | ecify Yes or No- Rican, etc.) | 14. Rac Blac Specify | ck, White, | etc. |
| no the matural, it, the Madeal En. | 15. Decedent's E | ducation | 16a. | Decedent's Usua | Occup | ation | t of work | ina | 16b. Kind of B | usiness/in | dustry |
| | Elementary/Secondary (0-12) | College (1-4o | r 5+) | (Give kind of worlde. DO NOT us | | | O WOIN | any . | | | |
| S F O | 12 years 17. Father's Neme (First, Middle, Last | 1 | P | ublic Re | ati | | r'e Name | /First Middle | Bankin Maiden Suman | 0 | |
| B C | William Winefor | | n | | | Mary | | Catheri | | nke | |
| To Be Co | 19e. Informent's Name/Reletionship | | | . Meiling Address | (Street | | | | | | Code) |
| If tem 27 is marked other than or other traumatic event, the little To Be Comp | Carol Miglioretti | (daught | er) 9 | Thaxton | Ct. | Timo | nium | , Maryl | and 210 | 93 | |
| 9 | 20a. Method of Disposition 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ | Dommuni from Stat | comete | Disposition (Nan ry, cremetory or o | ne of ther plac | ce) | 1 | Dete | 20c. Location - | City or To | own, Stete |
| o An | 4 Donetion 5 Other (Special | | Loudor | Park Ce | emet | ery | 1- | -21-200 |) Balt | imore | , Maryland |
| Important: If Itam 27 any Injury or other to once. | 21. Signeture of Funeral Service Lice 23a. Pert1. Enter the disease, or comshock, or heart failure. List only | _ | · · · · · · · · · · · · · · · · · · · | 22. Name en Mitche | 11_t. | Ti adat | 6014 | Funera | l Home, | Inc. | 21212 |
| ysician Medical aminer Examiner | Immediate Cause (Final disease or condition resulting In death) | a. Comp | Due to (or as e | consequence of): | est ole | Tax | ilu | n. | | 1 | Intervel Between Onset end Death UKCL JUNE JU |
| physician and the burlet-transit dical Examin | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | . Dou | Due to (or es a d | eune | | | | | | | years |
| ed by the attending pi detached for use es t detached for use es t detached for weeks t | L | d | | | | | | | | 1 | |
| hed for | Pert II. Other significant conditions of | contributing to death | but not resulting tr | the underlying c | ause giv | en in Pert I | | 23b. Dld 1 | tobacco use co | ntribute to | o the cause of death? |
| be detach by Phy | | | | | | | | 10 | Yes 20 No | 3 □ Pro | bebly 4□Unknown |
| 2 should 2 should pleted | | | | | | | | | en eutopsy rmed? | av | ere autopsy findings ailable prior to impletion of cause death? |
| drector, pege drector, pege To Be Corr | | | | | | | | 10 | Yes 22 No | 1[| ☐ Yes 2☐ No |
| Be | 25. Was case referred to medicat axaminer? | Hospitel: | | | Oth | | of Deat | h (Check only o | ne) | | |
| S 7 | 1 Yes 2 No 27. Manner of Death 1 Netural 5 Pending 2 Accident investigatio | 28a. Dete of in (Month, D | | | 8c. Injur Wor | 4LI NU | | | dence 6 Oth | | (y) |
| To the Funeral Director: After to completely filled in by the funeral Medical Certification: | 3 Suicide 6 Could not b | 289. Place of I | njury - At home, fa etc. <i>(Specify)</i> | rm, street, fectory | , office | | | 28f. Location (S City or Tox | | ber or Rura | al Route Number, |
| To the Funeral Direct completely filled in by Medical Certifi | 29a. Certifier (Check only one) 1 Certifying Pt 2 Medical Exar | nysician: To the bes niner: On the basis and menner s | of examinetion an | , deeth occurred d/or investigation, | et the tir in my o | ne, date an pinion, dee | d place, th occurr | and due to the ed at the time, | cause(s) end made and place, | anner as s and due to | tated. o the cause(s) |
| To the Funeral completely filled Medical C | 29b. Signature end title of certifier | okuju | in | 111 | | e number | 20 | | 29d. Date signe | id (Month, | Day, Year) |
| Ø | 30. Name and address of person who | completed cause of | death (Item 23a) | (Type, Print) | Fre | den | ik | Ret & | Ultimor | 1 21 | 1328- |
| State Registrar | JAN 2 8 200 | 32. Regis | trer's Signeture | 4 6 | | | | | | | |



State of Maryland / Department of Health and Mental Hygiene-Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Eula M. Henneberger 2000 January 23, 6:45pm /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Colonial Manor Nursing Home Crofton Anne Arundel If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Davs Hours Min. 1□M 2X F Months 216-34-8535 87 Yrs Director Oct. 15,1912 West Virginia Usual Residence of Decedent 10h County 10c. City, Town or Location 10d. Inside City Limits "natural", or flams 23s or 28s-f show the Medical Examiner must be notified at MD N Yes 2 No Director Annapolis Anne Arundel 729 Glenwood Street, 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 729 Glenwood Street 21401 IISA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status hours after 1 Never Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yes ZENo Specify: White Specify þ 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Restauranteur Food Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If Nem 27 is marked or Albert Miller Wikel 2 Ada Gertrude Charles 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Flural Floute Number, City or Town, State, Zip Code) John A. Henneberger (Son) 4 Carrick Road, Palm Beach Gardens, FL 33418 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 01/26/ 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metro Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2000 Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. altre 12 Ridgely Avenue, Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one cause on each line. Approximata Interval Between Onset end Death **Physician** /Medical Immediate Cause (Final Congestive Heart Failure 6 mos disease or condition resulting in death) Examiner Due to (or as a consequence of): Chronic Obstructive Lung Disease 15 yr physician and s the burial-transit certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury Ihat initiated events rasulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical Due to (or as e consequence of) US0 25 Mending P.O. 1 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? 6 ¥XYsa 2 No 3 Probably 4 Unknown signed t Records, p 8 24b. Were sutopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy Deen The law certificate has b lirector, page 2 s 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vitai To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, it Be 25. Was case referred to medical exeminer? 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Menner of Death 28a. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred Certification: 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, term, street, factory, office building, etc. (Specify) 4 Homicide edical 29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated.

I Medicat Examples: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and little of certific 29d. Dete signed (Month, Day, Year) 29c. License number D 18529 January 24, 2000 30. Name any address of person why completed cause of death (tem 23a) (Type, Print) 2009 Tidewater Colony Drive, #2A, Annapolis, MD 21401 Jon Lowe, MD.

DHMH 16 Rev 6/95

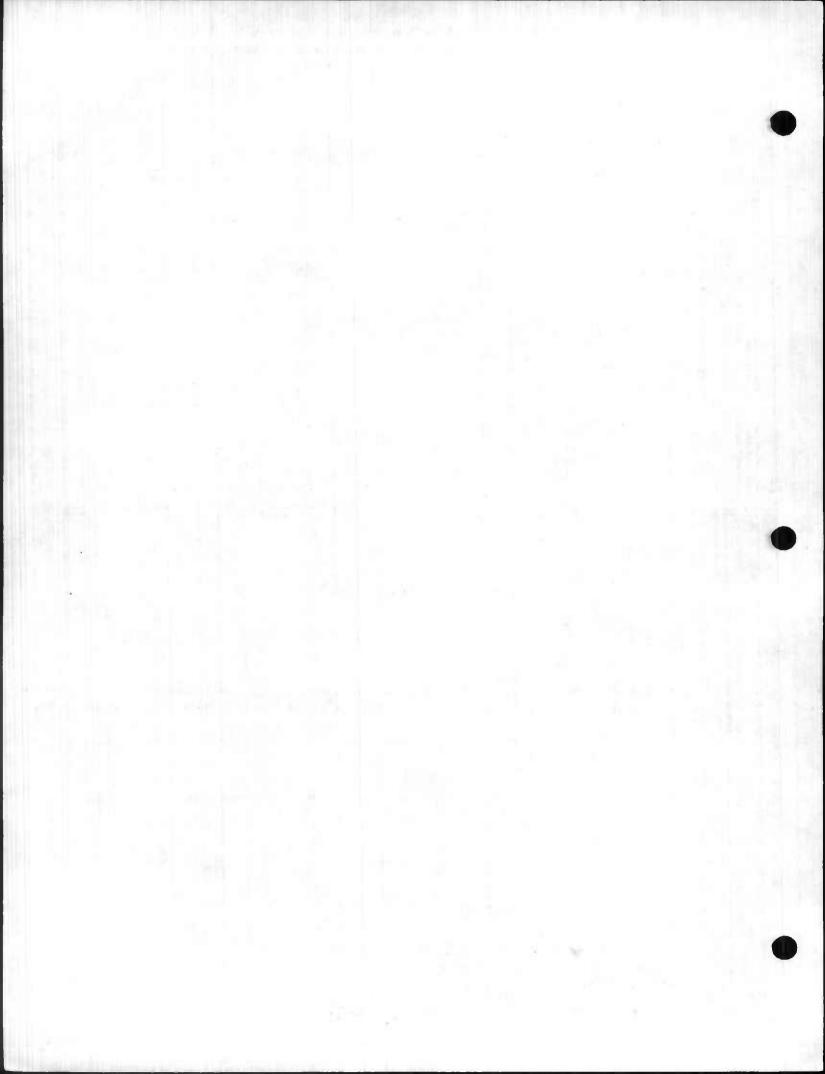
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Registrar

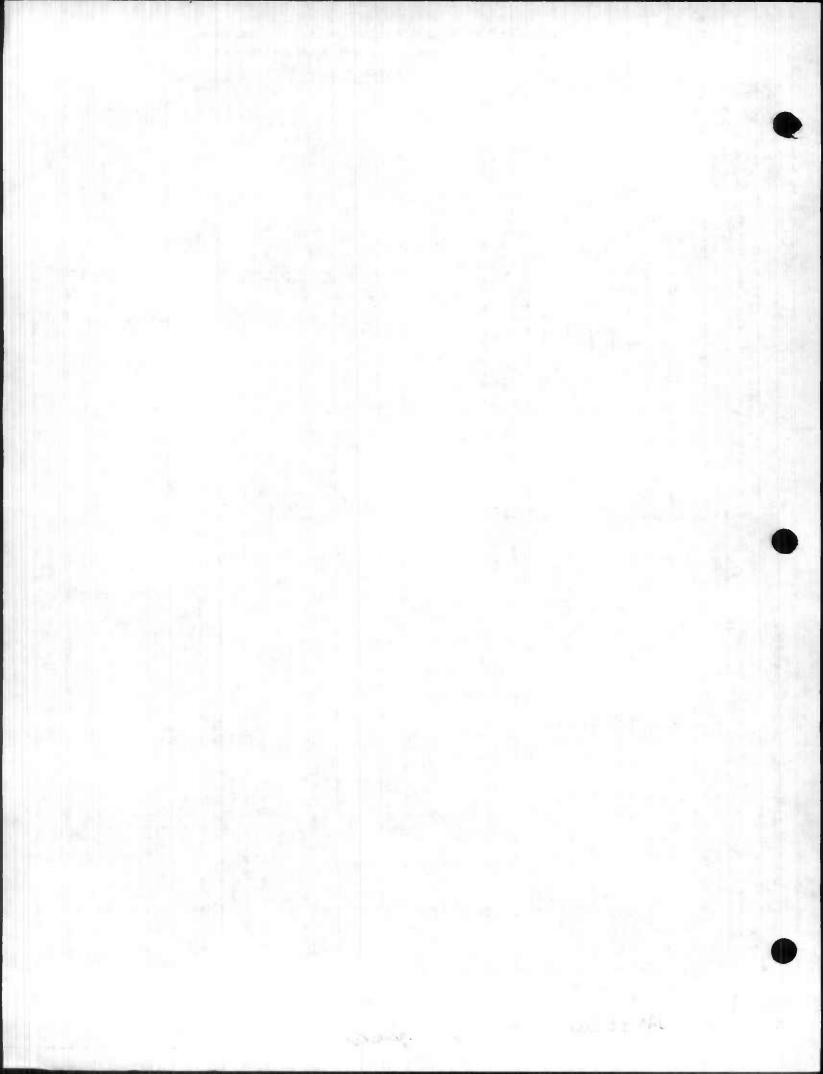
31. Date filed (Month, Day, Year)

JAN 28 2000

32. Registrar's Signature

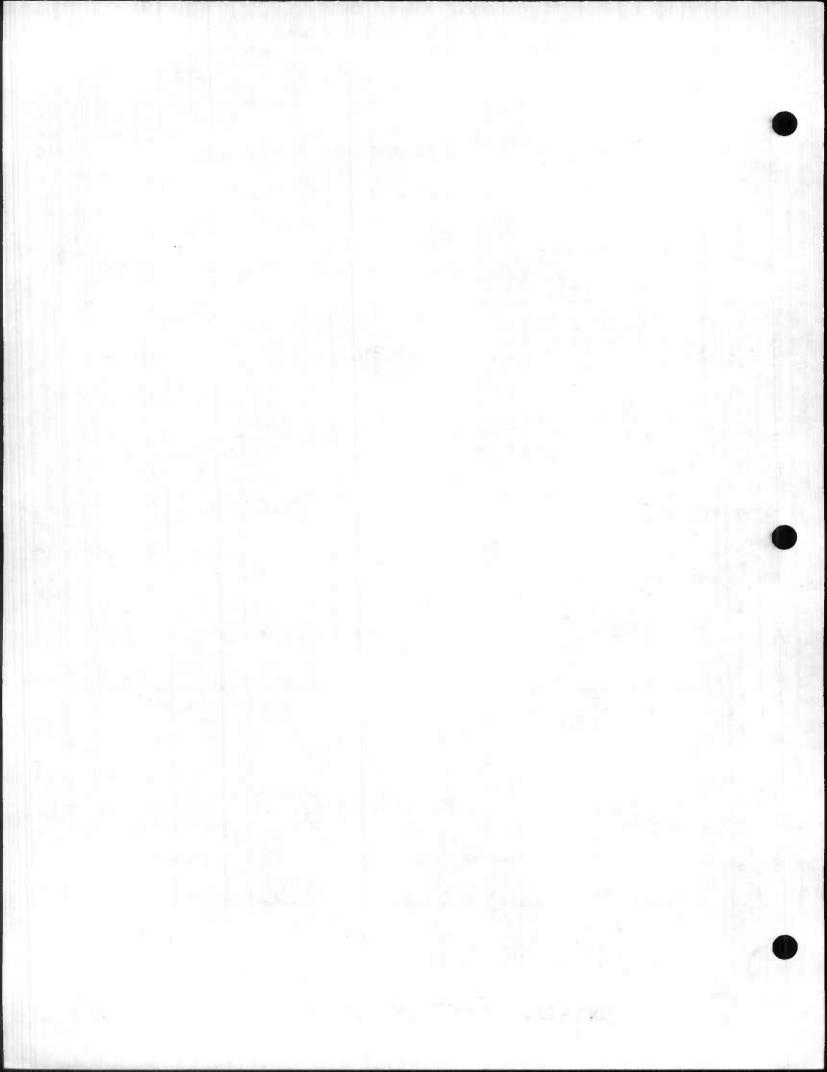


| /sician | | ne (First, Middle, La | - | | | rtificat | | | | 2. Date of Do | Day - | Year_ | 3. Tima of Death |
|--|---|--|--|---|--|--|--|--|---------------------------|--|---|--|---|
| /sician ledical | Georg | | Head | 57 | | | | | | TANUA | ICA CT | 2000 | 10:33 AM |
| ıminer | 4a Facility Name | | PITAL | | | | 1 | | t Imo | ocation of Dear | th 4c. Count | y of Death | |
| ral | 5. Social Security | Number 6.3 | Sex 7. Ag | | last birthdey, | If Under | | If Under | | 8. Date of Bi (Month, D | rth | 9. Birthpl | ace (State or Foreign |
| | 226–18– | 1000 | 1√2 M 2□ F | 77 | Yrs. | Months | Deys | Hours | Min. | Nov 15 | | P | Ä. |
| | Usual Residence of | 10b. County | | | , Town or L | | | | | | | 10 | Od. Inside City Limits |
| tor | MD. | Baltimo | re | (| Catons | sville | 3 | | | | | | 1 ☐ Yes 2 No |
| Director | 10e. Street and No | umber | | | | 10f. Zip | Code | | | | 10g. Citizen of | What Coun | try? |
| <u>a</u> | 11 Nort | h Hillton | Road | | | | | 21 | 228 | - | U.S.A. | | |
| by Funeral | 11. Merital Status | rried 2/2 Merried | 12. Was Decedent Armed Forces? 1 Ves 2 I If Yes, Give | | S. 13. | Was Deced If Yes, spec | ify Cubi | fispanic Or an, Mexica Specify | n, Puerto | ecify Yes or N Rican, etc.) | Bla | ca - America ck, White, e | |
| | 3 🗆 Widowed | 4 Divorced | Year or Dates: | WWII | | 10 165 | E TOT 140 | эреспу | | | Speci | W | hite |
| Completed | (Spe | 15. Decedent's E ecity only highest gr | ducation ade completed) | | 16e. Dece (Give | edent's Usua e kind of wo DO NOT us | d Occup | ation duning mos | st of work | ing | 16b. Kind of E | Business/Ind | lustry |
| - | Elementary/Sec | condery (0-12) | College (1-4or : | 5+) | | ist/o | | | | | graphi | lc art | S |
| | 17. Father's Name | (First, Middle, Last |) | | | | | | | | e, Meiden Sumai | me) | |
|) | | F. Head | | | | | | | | ta Mae | | | |
| | | ead, wife | (Type, Print) | | 19b. Maili 11 N | ing Address orth l | (Street Hill | top F | Rd., | al Route Numi Catons | ville, | Ad. 21 | 228 |
| | | | Removal from State | 0.0 | lece of Dispendence of the Dispe | melaniara | that nia | ce) rton (| Crem. | Date 1/27/ | 20c. Location 00 Lau | cel, M | |
| | | uneral Service Lice | | | 2 | 2. Name en | d Addre | ss of Facil | lity | | | | |
| | 15/2 | ala. I | P | 22) | W | itzke | Fur | eral | Home | of Ca | tonsvil. | le, Ir | nc. 21228 |
| | 23a. Part1. Enter | the disease, or con | one ceuse on each li | the death | n. Do not en | nter the mod | e ot dyli | ng, such es | s cardiac | or respiretory | arrest, | rid. 2 | Approximate Interval Between |
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| /Medical Examiner | An English Name (Mant Institution of a | | R | | | | wn, or Location | on of Death | 4c. Count | by of Death ARUNI | |
| Funeral Director | 5. Social Security Number 6. Sec 112 | 7. Age (In yrs | last birthdaj Yrs. | Months | 1 Year Days | If Undar 2 Hours | Min. | Data of Birt Month, Day | h v, Year) | 1 | laca (Stata or Foraign |
| 2 . | Usual Residence of Decedent 10a. Stata 10b. County | 100 0 | ty. Town or I | Lacation | | | | | | | |
| with the Maryland a or 28s-f show the notified at Director | | | | Glen Burnie | | | | | 10d. Inside City Limits 1 ☐ Yes 2 ☑ No | | |
| viih the Ma to 286-f a be notified | 10e. Street and Number | index | 016 | 101. Zip | | | | | 10g. Citizen ol | What Coun | ** |
| her death with the Maryla herra 23s or 28s-f sho iner must be notified at Funeral Director | | | | | 21060 | | | | United | d Stat | es |
| 5-0020 72 hours after death v natural, or flerre 23 steal Examiner must | 3 Widowed 4 □ Divorced | 12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: | J,S. 13 | If Yas, spec | | | gin? (Specify , Puarto Rica | arto Rican, etc.) | | Race - American Indian, Black, Whita, atc. | |
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| Maryland 21215-0020 3.2 should be filed within 72 hours at hard Mental Hygiene. The marked other than "natural", or traumatic event, the Medical Examp To Be Completed by F | Elementary/Secondary (0-12) | College (1-4or 5+) | | arpent | |) | | | Cor | nstruc | ction |
| Be C | | | | | | 18. Mother | r's Nama (Fil | rst, Middle, | Maidan Suma | | |
| ylar Menta M | | | | | |] | Irene | Unkn | own | | |
| Age 2 sho | 19a. Informant's Name/Relationship (Ty | | | | | | | | r, City or Town | | |
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| altimore mit. Pages 1- partment of He portant: if Ihan y Injury or oth | 20a. Method of Disposition 1 Burial 2 \(\Delta\) Cremation 3 \(\Delta\) A \(\Delta\) Donation 5 \(\Delta\) Other (Specify) | lemoval from State | cemalary, cr | ematory or o | ther plac | , | JAN | 27 00 | 20c. Location | | |
| Balt permit Departiment import any inj ands | 21. Signature of Funeral Service License | ogh | K | | Y-RU | DDICK | FUNER | | ME, P.Z BURNII | | 21061 |
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| P.O. Detach | | tributing to death but not re | sulting in the | underlying c | ausa giv | en in Part I. | | | res 2 No | | the cause of death? bably 4 Unknown |
| Records he law requires a has been sign age 2 ahould be | | | | | | | | | an autopsy med? | cor of c | ere autopsy lindings allabla prior to mpletion of causa death? |
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| of Vita Physician: this cartific ral director, | 1 ☐ Yes 2 🖾 No | lospital: 1 Inpatient 2 | ER/Outpati | | | 4 🗆 1401 | rsing Homa | 5 🗆 Rasio | lence 8 🖽 O | thar (Specify | |
| C 5 5 5 0 | 27. Manner of Death 1 🖾 Natural 5 🗆 Pending 2 🗆 Accident investigation | 28s. Data of Injury (Month, Day Year) | 28b. Tima Injury | of 2 | 8c. Injun Worl | yat k? Yas 2∐N | | Describe h | low injury occu | irred | |
| Division of the Hospital or Attanding P within 24 hours after death. To the Funeral Director: After I completely filled in by the funer Medical Certification: | 3 Suicide 6 Could not be 4 Hornicide determined | 28e. Place of Injury - At h building, etc. (Speci | oma, larm, s | street, tactory | , office | | 281. | Location (S City or Tow | Street and Num m, Stata) | iber or Rura | il Route Number, |
| ne Hoeplu n 24 hours he Funeral pletaly fille | | ician: To the best of my known: On the bases of axamino | owledge, dea ation and/or i | ath occurred a invastigation, | at tha tim in my o | na, data and pinion, daati | d place, and h occurred a | dua to tha d t tha tima, d | causa(s) and n data and place | nannar as st | ated. tha cause(s) |
| To the Within To the compl | | do h | | | License 200 | 94 | | | 29d. Date sign JANUAR! | | |
| 9 | 30. Name and address of person who con ELLIOTT GORBATY, | | | | GLEN | BURN | IE, MA | ARYLAN | ND 2106 | 1 | |
| State | 31. Data liled (Month, Day, Year) | 32. Registrar's Sign | atura | 9. de | Down | 2 | | | | | |

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienen Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year William Homer Hagy January 20 220A 2000 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Fallston Fallston General Hospital Harford If Under 1 Ye If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Hours 1□M 20 F Months Days 217-07-8834 Baldwin, MD Dec.25,1915 Usual Residence of Decedent 10s. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Baltimore Kingsville 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 11813 Reynolds Road 21087 U.S.A. 12. Was Decedent Ever in U.S. Amed Forces? 1.2Yyes 2 □ No. ARMY If Yes, Give 11/13/43-Year or Dates: 4/29/46 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Stalus Bieck, White, etc. 1 Never Married 2 (X) Married 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 6 yrs. n/a Foreman Tree Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Jacob Thomas Hagy Lena Lane 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marie C. Hagy (wife) 11813 Reynolds Road Kingsville, MD. 21087 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete Date 1 Burial 2 Cremation 3 Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) Zion Cemetery 1/24/2000 Baltimore, MD. 21. Signature of Funeral Service Liberane 22. Name and Address of Facility Lassahn Funeral Home 11750 Belair Road Kingsville, MD. 21087 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervel Batween Onset and Deeth Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23b. Did tobacco use contributa to the causa of death? Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? No 1 Yas 1 Tyes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 1 Yes 2 ER/Outpetient 3 DOA Manger of Deat 28a. Data of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1. Selatural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be 3 Suicide 281. Location (Street and Number or Rurel Route Number, City or Town, Stata) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide

Box 68760, P.O. of Vital Records. or Attending Physician: **Physician**

/Medical

Examiner

Director

Funeral

by

Completed

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Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Manylen nent of Heelth and Mentel Hygiene.
ant: if item 27 is marked other than natural, or items 23s or 28s-1 show usy or other than usy or other training must be notified at ury or other training.

Item 2 other t

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Physician /Medical

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Certification: To

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29a. Certifie

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(Check only one)

29b. Signature and little of certified

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Baltimore, Maryland

Division

completely within 2

DHMH 16 Rev 6/95

State

Registrar

31. Date filed (Month, Day, Year) JAN 28 2000

J. / [Im



Walnut

Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and mannar as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.

29c. License number

29d. Dete signed (Month, Day, Year)

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B 2008

124 28 2000 James & Marie

Please Type or Print in Black Indelible Ink. Assure Ali Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Day Year **Physician** John MOMAS 8:00 AM 9N 2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner High HANCOCK wes! wa 8. Date of Birth (Month, Day, Year)
July 25,1934 If Under 1 Year 5. Social Security Number 9. Birth face Country) WV 7. Age (In yrs. last birthday) nce (State or Foreign **Funeral** Days Min. Months Hours **™** M 2 F Yrs. 65 Director 214-34-9770 the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits show 1 ¥Yes 2 □ No Director 28a-f MD Washington Hancock 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? Herne 23s or 21750 213 High Street USA Funeral Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U.S. 14. Race - American Indian. 11. Meritel Stetus Armed Forces?

1 XYes 2 No
If Yes, Give
Yeer or Detes: Black, White, etc. filed within 72 hours after 1 Never Merried 2 Merried altimore. Maryland 21215-0020 "natural", or 1 ☐ Yes 2 No Specify: À 3 ☐ Widowed 4 X Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiens. Elementery/Secondary (0-12) College (1-4or 5+) 12 Bookkeeper Restaurant permit. Pages 1 and 2 ahould be file.
Department of Health and Mental Hy, important if from 27 is married other any Injury or other treasment. 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 8 2 George W. Helsley Rachael Harr 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Nancy Carpenter/Friend 202 Annex St. Apt.4 Berkeley Springs, WV 25411 20b. Ptece of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBuriel 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donelion 5 ☐ Other (Specify) Greenway Cemetery 1/26/2000 Berkeley Springs, W 21 Signature of Funeral Segrica Licenses 22. Neme end Address of Facility Grove Funeral Home, P.A. 141 W.Main St. Hancock, MD 21750-0368 23a. Part1. Enter the disease, or complement that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediete Cause (Final disease or condition resulting in deeth) Examiner Examiner attending physician and for use as the butal-transit The law requires that the death certificate be executed pue . Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Due to (or es e consequence of): P.O. Box 68760, Physician/Medical Due to (or es a consequence of) signed by the at d be detached for Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, þ 24a. Wes an eutopsy performed? 24b. Were autopsy findings available prior to Completed completion of cause of death? page 2 2 No certificate 1 ☐ Yes 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certific 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) examiner/ 1 No 2 No Other: 4 Nursing Home ome 5 Mesidence 6 Other (Specify)
28d. Describe how injury occurred Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Dey Year) 27. Megner of Death 28b. Time of 28c. Injury at Work? 1 Neturel 5 Pending 1 ☐ Yes 2 ☐ No investigetion 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide n 24 hours a 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred et the time, date end place, and due to the cause(s) within 24 hou To the Funer completely fil 29a. Certifier end manner steted. ş 29b. Signature and title of certifie 29c. License number 29d. Dete signed (Month, Day, Year)

State Registrar

DHMH 16 Ray 6/95

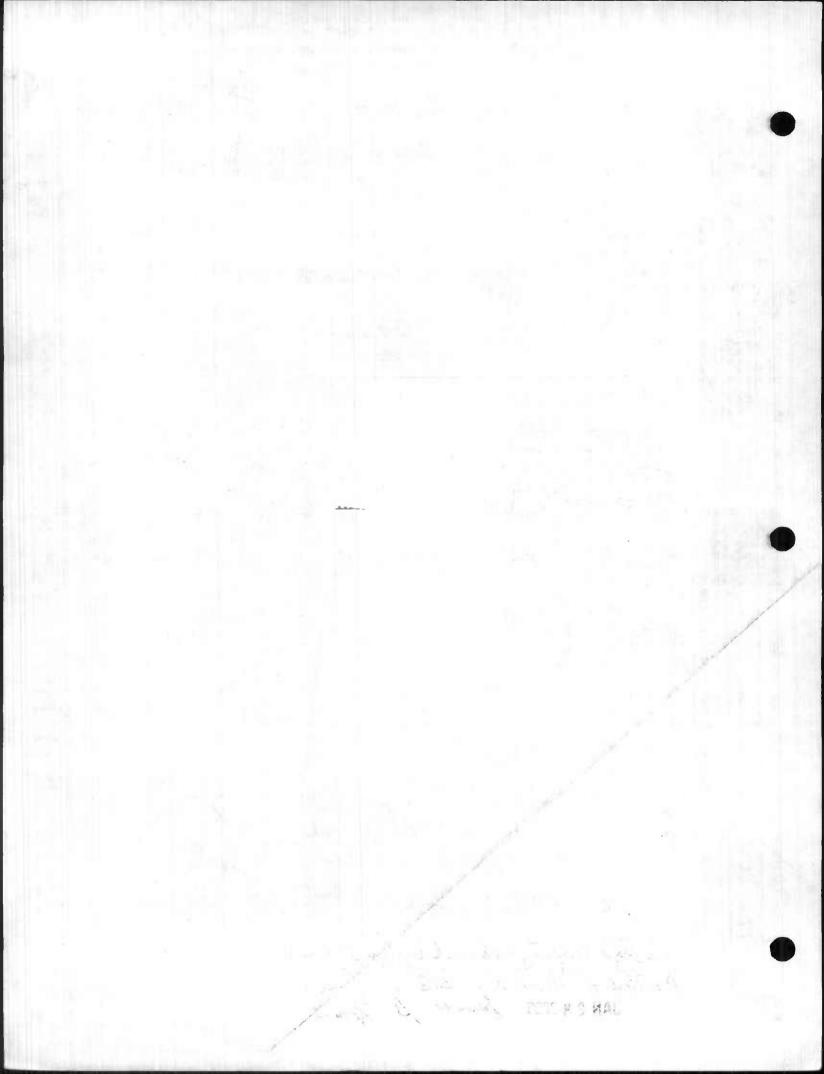
8/8 31. Date filed (Mon.

30. Name end address of person who

32. Registrar's Signature

cause of death (Item 23a) (Type, Print)

2000



| | 1 | 43.000.00 | W7 40 " " | Stat | e of Mar | yland (E | epartm | ent of | Health and I Death | Mental Hyg | iene | 2 00 | 0.00 |
|--|--|---|--|---------------------------------|--|---|---|-----------------------------------|--|--|--|---|--|
| DERNLE | EIN | AMEND IT | | | I, 27 | PER | Certific | cate of | Death | Re | g. No. | 1 02 | 129 |
| Physi | ician | 1. Decedent's Nan | e (First, Middle | e, Last) | | | | | | 2. Date of Death Month | Day | Year 3. | Time of Death |
| /Med | | Marya | | Hoern: | | | | | | JANUARY | - | | :50P.M. |
| Exam | niner | 4a Facility Name (| | | nd number) | | | | 4b. City, Town, or | Location of Death | 4c. Count | | |
| | | 1907 QU 5. Social Security I | | 6. Sex | 7 800 / | 'In yrs. last bir | thefore) If LI | Inder 1 Yea | DUNDALK | 8. Date of Birth | BALI | IMORE | Ctata as Essaia |
| Funera Directo | _ | 219-40- Usual Residence of | 2668 | 1□ M 20 | | | | nths Days | | (Month, Day, 12 16 | | Country) Md | State or Foreig |
| with the Maryland a or 28a-f show Lbs.notified.at | | 10a. State | 10b. County | | 1 | Oc. City, Town | or Location | | | | | | side City Limits |
| iar death with the Marylar Rema 23a or 23a-f show Iner must be notified at | ctor | Md | Bal | timore | е | Dur | dalk | | | | | 1 | Yes 2 No |
| 0 to 10 | Director | 10e. Street and Nu | | | | | | f. Zip Code | | 10 | g. Citizen of | What Country? | |
| 23s | E | 1907 Q | ueensw | ay | | | | 21222 | 2 | | US | A | |
| tama tama | Funeral | 11. Marital Status | | Armo | Decedent Eve ed Forces? | er in U,S. | 13. Was D | ecedent of specify Cui | Hispanic Origin? (S ben, Mexican, Puerl | pecify Yes or No- to Rican, etc.) | | ca - American In ick, White, etc. | dian, |
| hours after ural, or its al Examina | by | 1 Never Man | | If Ye | Yes 2 No es, Give r or Dates: | | | es 2 No | | | Specil | Whit | |
| 일 호텔 | Completed | (Spe | 15. Decedent city only highes | | eted) | 16a. | Decedent's (Give kind of life, DO NO | f work done | a during most of wor | | 16b. Kind of B | Susiness/Industry | |
| within pre. then | dmo | Elementary/Sec 1 2 | ondary (0-12) | Colle | ege (1-4or 5+) | | | | 80) | | Law O | ffico | |
| Hyginal Hyginal | | 17, Father's Name | (First, Middle, | Last) | | | ecre | Lary | 18. Mother's Nar | ne (First, Middle, N | | | |
| id be settal | To Be | Wayne | Fowl | or | | | | | Anne | Manag | | | |
| ahou man | - | 19a. Informant's N | | | | | | | | Taras ural Route Number, | City or Town | , State, Zip Code |) |
| and 2 salth a n 27 ts er trai | | Chester | nusban | nd 11 | 116 Bonsal St., Baltime | | | altimor | e. Md | . 2122 | 4 | | |
| -116 | | 20a. Method of Dis | position | | | 005 01 0 | Dianastias | /Alama a al | ace)Crem. | | | - City or Town, S | |
| Pages net of net if the nry or o | | | Cremation 5 ☐ Other (S) | | from State | Balti | more | Wash | ington | 01 28 | Laure | 1, Md. | |
| mit. | 16 | 21. Signature of Fr | uneral Service | Licensge | $\cap \Lambda$ | | 22. Nam | e and Add | ress of Facility Ashton | | | | |
| Physicia /Medica | | 23a. Part1. Enter shock, or her | the disease, or art failure. List | complications only one cause | that caused th | e death. Do r | 213 | 4 Wi | llow Spr | ing.Rd. | Balt | App | 2 1 2 2 2 roximate |
| Examine | r | Immediate Cause disease or condition resulting In death) | on | a | DIABE | ETIC KE | ETOACI | DOSIS | ring, such as cerdia: | c or rešpiratory arre | est, | Ons | val Between et and Death |
| te be executed ysicien and he burial-transit | Examiner | disease or condition | onditions, nmediate erlying I Injury s | a b c | DIABE | ETIC KE | CTOACII consequence | DOSIS ool): | ing, such as cerdia | c or rešpiratory afre | ist, | Ons | |
| eath certificate be executed stending physicien and for use as the burial-transit | Examiner | disease or conditi- resulting in death) Sequentially list or if any, leading to licause. Enter Und Cause (Disease or that initiated event resulting in death) | onditions, mmediate erlying Injury s Last | a | DIABE Du Du | ETIC KE ue to (or as a due to (or a) due | CONSEQUENCE consequence consequence | DOSIS a ot): a ot): | 6 | | | | et and Death |
| that the death certificate be executed ed by the ettending physicien and detached for use as the bunel-transit | Physician/Medical Examiner | disease or conditi- resulting In death) Sequentially list or if any, leading to li- cause. Enter Und Cause (Disease or that initiated event | onditions, mmediate erlying I hijury s Last | - | DIABE Du Du | ETIC KE Je to (or as a of Je to (or as a of) | CONSEQUENCE consequence consequence | DOSIS a ot): a ot): | 6 | 23b. Did to | bacco uae ce | ontribute to the | cause of seath |
| be lew requires that the death certificate be executed that been signed by the ettending physicien and the stending by solution by detached for use as the burial-transit to the stending by the burial-transit to the stending by the burial-transit to the stending by the s | by Physician/Medical Examiner | disease or conditi- resulting in death) Sequentially list or if any, leading to it cause. Enter Und Cause (Disease or that initiated event resulting in death) Part II. Other signi | onditions, mmediate erlying I hijury s Last | - | DIABE Du Du | ETIC KE Je to (or as a of Je to (or as a of) | CONSEQUENCE consequence consequence | DOSIS a ot): a ot): | 6 | 23b. Did to | bacco use co | ontribute to the 3 Probably 24b. Were a | cause of seath 4 Junknow utopsy findings e prior to |
| The law requires that the death certificate be executed the last been signed by the ettending physicien and page 2 should be detached for use as the burial-transit of the last better the last burial transit of | Completed by Physician/Medical Examiner | disease or conditi- resulting in death) Sequentially list or if any, leading to it cause. Enter Und Cause (Disease or that initiated event resulting in death) Part II. Other signi | onditions, mediate orlying Injury Stast | C CARD | DIABE Du Du | ETIC KE Je to (or as a of Je to (or as a of) | CONSEQUENCE consequence consequence | DOSIS a ot): a ot): | given in Part I. | 23b. Did to 1 74 24a. Was air perform | bacco uae ce na 2 No n autopsy ned2 | ontribute to the 3 □ Probably 24b. Were a available comple of deatt | cause of seath 4 Junknon utopsy findings e prior to ion of cause |
| The law requires that the death certificate be executed the last been signed by the ettending physicien and page 2 should be detached for use as the burial-transit of the last better the last burial transit of | o Be Completed by Physician/Medical Examiner | disease or conditi- resulting in death) Sequentially list or if any, leading to it cause. Enter Und Cause (Disease or that initiated event resulting in death) Part II. Other signi | onditions, mediate orlying Injury s Last | C CARD | DIABE Du Du | ETIC KE Je to (or as a de le to (or as a de) | consequence consequence consequence in the underly | DOSIS a of): a of): ing cause g | given in Part I. 26. Place of De | 23b. Did to 1 74 | bacco uae co aa 2 No n autopsy ned? | ontribute to the 3 □ Probably 24b. Were a available comple of death | cause of seath 4 Junknow utopsy findings e prior to |
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State Registrar

DHMH 16 Rev 6/95

05 31. Date filed (Month) e

30. Name and address

29b. Signature and title of cert

32. Registrar's Signature

ORIGINAL

29c. License number

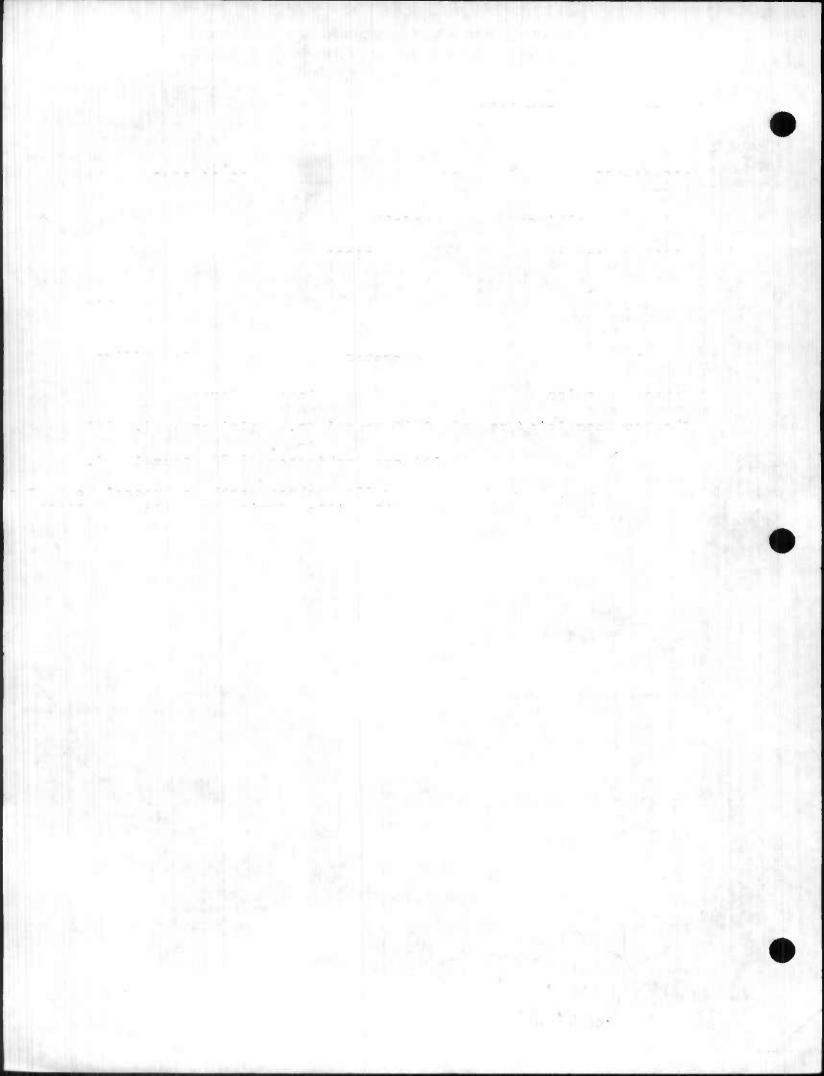
O.C.M.E.

pleted cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201

29d. Date signed (Month, Day, Year)

JANUARY 20,2000

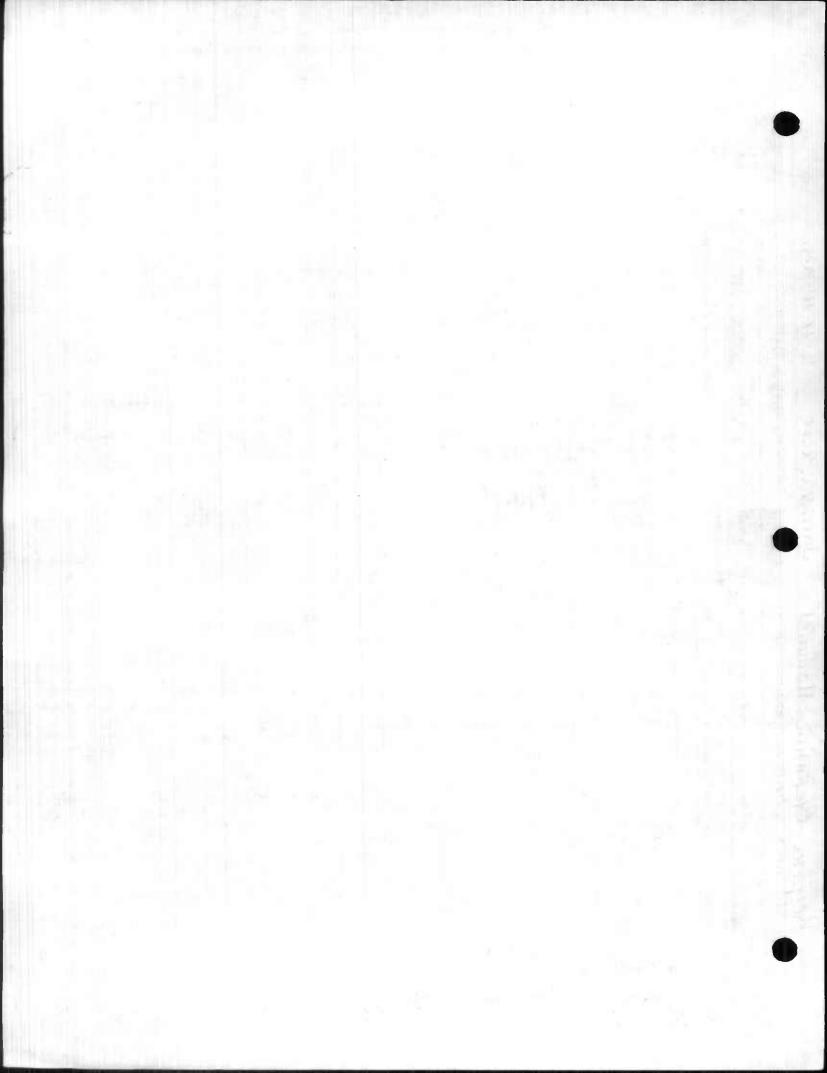
FEB 04



State of Manyland / Department of Health and Mental Hygiene

| | 1. Decedent's N | ame (First, Middle, Lu | ıst) | | Ce | rtificate | e OI I | Deam | 2. Date of De | Reg. No | | 3. Tima o | of Death |
|--|--|---|----------------------------|--------------------------|----------------------------|----------------------------|--------------------|--|--------------------|------------|-----------------------------|--|-----------|
| Physicia | 7(-1 | gina Russo | Hammel | | | | | | January | 22 22 | 2000 Yaar | 4:10A | М |
| /Medic Examin | 4a Casilla Name | (If not institution, gi | e street and nu | mber) | | | 4 | b. City, Town, or | | | . County of De | | |
| | | christ | | | | | | Towson | | В | altimore | | |
| Funeral | 5. Social Security | | Sex | 7. Aga (In yrs. | | Months | | If Under 24 Hrs Hours Min. | | rth | 9. B | rthplaca (State country) yland | or Fore |
| Director | 219-03-6 | 210 | 1□M 2KDF | 79 | Yrs. | | | 12000 | July 30 | 192 | 0 Mar | yland | |
| P | Usual Rasidence | 10b. County | | 10c. Ci | ty, Town or L | ocation | | | | | | 10d. Insida C | tity Limi |
| f shorts | MD. | Baltimore | | | imonium | | | | | | | 1 🗆 Yas | |
| with the Maryla a or 28a-f show the notified at | MD. 10e. Street and I | | | | | 10f. Zip | Code | | | 10g. Cit | izen of What C | Country? | |
| Sa o | 2104 Fo | untain Hill | Dr. | | | 2 | 093 | | | | US | | |
| C mark | 2104 FO | | 12. Was Dec | edant Evar in U | ,S. 13. | | | lispanic Origin? (S on, Mexican, Puar | pecify Yes or N |)- | 14. Rece - Am | | - |
| or the | 1 Never M | arried 2X Married | Armed Fo | | | 1 ☐ Yas 2 | | Specify: | io Hican, atc.) | | Black, Wh | ita, atc. | |
| 0020 hours sher tursif, or its | | I 4 □ Divorced | Yaar or D | atas: | | | | | | | Specity: | White | |
| To Table | (S) Elementary/Se | 15. Decedent's E pecify only highest gra | ducation ade completed) | | 16a. Dece (Give | dent's Usua kind of wor | k done o | ation during most of wo d) | rking | 16b. K | ind of Businas | s/Industry | |
| vitte in the little in the lit | Elementary/Se | condary (0-12) | College (| | | | | ") | | - | ducation | | |
| d Had | 17. Father's Nam | a (First, Middle, Last | | 6 | SCHOOL | Teache | 21 | 18. Mother's Ne | ma (First, Middle | | | | |
| land of the state | 17. Father's Nam Phill | ip Russo | | | | | | Rose P | apale | | | | |
| laryla 2 should and Man a marks aumatic | | Name/Ralationship | Type, Print) | | 19b. Mail | ing Addrass | (Street | and Number or R | ural Route Numb | er, City o | or Town, State, | Zip Code) | |
| Manda and 2 and 27 is ar tran | Mr. Rober | t T. Hammel/ | Husband | | 2104 | Fountai | n Hi | ll Dr. Tim | onium, MD | . 210 | 93 | | |
| Baltimore, Maryland 21215-0020 permit. Pages 1 and 2 should be filed within 72 hours all Department of Health and Marial Hydiantment of Health and Marial Hydiant in Informatical Health and other than "natural", or any Injury or other traumatic event, the Medical Examigina. | 20a. Mathod of D | | 3p | 20b. I | Place of Disponentery, cre | osition (Nan | ne of ther plea | (a) | Data | 20c. Lo | ocation - City o | r Town, Stata | |
| Page Page ment of any or | | 2 ☐ Cremation 3 ☐ n 5 ☐ Other (Speci | | Jiala | rkwood (| | | | 1-26-00 | Park | ville, M | D. | |
| Baltin permit. Pa Departmen Important any injury ance. | 21. Signature of | Funerel Service Lice | nsee | 0 | 2 | | | ss of Facility | and House | Tue | | 64 | |
| m 89788 | K | A. | Faus | olim | | 10 10 | JCK 1 050 Y | owson Fune ork Rd. To | wson. MD. | 2120 | 4 | | |
| 3 7 1 | 23a. Part1. Ente shock, or h | r the diseese or con eart failure. List only | oncations this | aused the deat | h. Do not an | tar the mode | of dyin | g, such es cardia | c or respiretory a | rrest, | | Approxima Intarval Be | tween |
| Physician | | | | 1 | | | | | | | | Onsat and | Death |
| /Medical Examiner | Immediete Caus disease or cond resulting in deat | tion | a | Lun | 9 C | Anc | CY | | | | | 10 m | rong |
| | | , | | Dua to (| ras a conse | quenca of): | | | | | | | |
| per les | Sequentially list | | b | | | | | | | | | 1 | |
| 68760, ficate be execut physician and a the burial-tran | Sequentially list if any, leading to cause. Enter Ur Cause (Disease | conditions, immediate | | Dua to (c | or as a conse | quence or): | | | | | | | |
| 68760, finate be so physician is as the burial | I that initiated eve | nts | C | Dua to (c | r as e conse | quence of): | | | | | | 1 | |
| | 40 | 1) Last | | | | 400.700 0.7. | | | | | | 1 | |
| Box ath cert attending for use | Part II. Other sig | | d | | | | | | | | | 1 | |
| O death | Part II. Other sig | nificant conditions | ontributing to de | eath but not ras | ulting In tha | undarlying ca | usa giv | en in Part I. | 23b. Dld | tobacco | vaa contribu | ta to the cause | of des |
| P.O. that the ed by the detache | | | | | | | | | 1 🗆 | Yaa 2 | DN0 3□ | Probably 4 |] Unkr |
| | à | | | | | - | | | | | | | #: A1 |
| Vital Records, Ician: The law requires to certificate has been signa rector, page 2 should be rector. | Completed | | | | | | | | 24a. Was | ormed? | psy 240 | Wara autopsy available prior completion of | to |
| Res Page 2 ag | Ē | | | | | | | | | | | of death? | |
| E The | | | | | | | | | | | No No | 1 Yas 2 |) No |
| | 25. Was casa reaxaminer? | | Hospital: | | 5010: | | Oth | 26. Place of De | | | - Mari | // | |
| | - | | 28e. Deta | npatient 2 of Injury | 28b. Tima o | | Bc. Injun Work | 4LI Nursing I | foma 5 ☐ Ras | | 6 ⊠Other (Sp ry occurred | ecity) Has | Pic |
| On Maria | 1 Natural 2 Accident | 5 Pending invastigatio | | th, Day Year) | Injury | м | | k? Yas 2 ∐ No | | | | | |
| Division or Attending after death. Director: Atte | 3 ☐ Suicide 4 ☐ Homicid | 6 Could not b | 28a. Place | of Injury - At h | oma, farm, si | reet, factory | office | | 28f. Location | | | Rural Route Nur | nber, |
| O page | S S | | Dulidi | ng, atc. (Specil | 7/ | | | | Only Or 10 | , Jiale | 7 | | |
| toepl uner uner | 29a. Certifier (Check only | 1⊠ Certifying Pt 2□ Medical Exar | ysician: To the | best of my kno | wiedga, deat | th occurred a | t tha tin | na, data and place | n, and dua to the | causa(s | and mannar | as stated. | s) |
| 2225 | | | and man | nar stated. | and/or if | | | | oo at mo mile, | | | | -1 |
| 2 2 2 8 | 29b. Signatura a | or title of certifier | 110 | | Λ | | - | e number | _ | _ | | nth, Day, Year) | |
| | 41 | Hollon | 1/66 | 2,00 | y | | 19 | 5705 St. 1. | | Jan | UATYO | 12,200 | 0 |
| MIN | 30. Name find ad | | completed cause | / - | n 23a) (Type, | Print) | 0. | CL 1 | 206 | m | 21 | 205 | |
| 4 7 | 00-11-1 | onth, Day, Year) | | 6781 egistrar's Signa | | m | ومرر | 011 1 | audi | 1110 | 21 | | |

DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death 9.38pm Year Month MATFIELD HORTON JAN. 22 2000 4a Facility Nama (If not Institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death SAINT AGNES HOSPITAL N/A BALTIMORE | Months | Days | Hours | Min. | S. Data of Birth | Month, Day, Y | 9-18-21 5. Sociel Security Number 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country) 1□M 2√2 F 78 237-46-9182 Yrs. N.C. Usual Rasidence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. fnside City Limits 1 Ves 2 No BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 501 E. PRESTON ST. 21202 USA 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yas 22 ☐ No If Yes, Giva Yaar or Datas: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Whita, etc. 14 Nevar Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Business/Industry College (1-4or 5+) -0-Elementary/Secondary (0-12) -12-CAREGIVER HEALTHCARE 18. Mother's Nama (First, Middle, Maiden Sumama) 17. Fathar's Nama (First, Middla, Last) ARTHUR HORTON MARY O'NEAL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 1283 SUGARWOOD CIRCLE ESSEX, JOHN HORTON (SON) MARYLAND 21221 20b. Place of Disposition (Nama of cematery, crematory or other place) 20c. Location - City or Town, Stata 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State WOODLAWN CEMETERY 1-31-2000 BALTIMORE, MARYLAND 4 ☐ Donation 5 ☐ Othar (Specify) 22. Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 21. Signature of Funaral Sarvice Licensee Bree 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, about, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Death ASPIRATION PHEUMONIA Immediate Ceuse (Final DAYS disaasa or condition rasulting in death) Due to (or as a consequence of): HYpEROSMOLAR NON KETOTIC DA YS COMM Due to (or es e consequence of): Sequantially list conditions, if any, laading to immadiata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last YFAXS DIABETES MELITUS Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 20 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 1 ☐ Yes 2 No 1 Yes 2 No 25. Was casa refarred to medical 26. Place of Death (Check only one) axaminar? 1 ☐ Yes 2 ☒ No Hospital: 1 Inpetient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 28a. Deta of Injury (Month, Day Year) 27. Menner of Death 28d. Describe how injury occurred 28b. Tima of 28c. Injury at Work? Neture 5 Panding 1 ☐ Yes 2 ☐ No 2 Accident invastigation Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

signed l of Vital Records, MATHELD certificate or Attending Physician: After after death. To the Hospital or Atta within 24 hours after de To the Funeral Directo completely filled in by the

Physician

/Medical

Examiner

Funeral

Director

28a-f show

8 **harra 23s**

b

Hygiene.

2 should be to and Mental H is marked of

Capariment of Health and Capariment of Health and Unpostant: If them 27 is many injury or other traum 2006.

Physician

/Medical

Examiner

Baltimore, Maryland 21215-0020

Director

Funeral

Completed

Be

2

Physician/Medical by Completed Be Medical Certification: To

3 ☐ Suicide 4 Homicide 29a, Certifia:

6 Could not be datarmined

Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Agnes Hospit

29b. Signature and titla of certifiar

m./)

29c. License number 8135 95 29d. Data signed (Month, Day, Year) 1/22/00

State Registrar 31. Date filed (Month Day, Year) JAN 2 8 2000

30. Name and addrass of person who completed cause of death (Item 23a) (Type, Print)

GEOFAE SATTOE-BONNIE 32. Registrar's Signatura

Physician /Medical Examiner **Funeral**

Director

death with the Maryland r than "natural", or frame 23s or 28s-f show the Medical Examiner must be notified at or flams 23s or

Funeral Director

þ

Completed

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental hyglene. And the first of the state of the first of the state of the work of the world of the wo 21215-0020

/Medical Examiner Completed by Physician/Medical Examiner To the Hoopital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be netached for the man the funeral director, page 2 should be netached for the man the funeral director. Be Certification: To edical

Baitimore, Maryland Department of Important: If any Injury or page **Physician** Box 68760. Division of Vital Records, P.O.

1. Decedent's Name (First, Middle, Last) AM 40 12 PUIERDO JANUARY -000 ANNA 4b. City, Town, or Location of Death 4c. County of Death 4s Facility Name (If not institution, give street and number) Northwest Hospital Randallstown Baltimore ff Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 1 M 2 NF Yrs. 005-50-9377 75 28, 1924 Puerto Rico May Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits MD 1 Yes 2 No Baltimore Woodlawn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1345 Bida Drive 21207 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11 Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1⊠Yes 2□No Specify: Puerto Rican Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Housewife Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Rosendo Colon Maria Ortiz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1345 Bida Drive, Woodlawn, Maryland 21207 Nelson Izquierdo (Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Data 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Garrison Forest VA Cem. 12/1/00 Owings Mills, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Puneral Service Licensee 22. Name and Address of Facility Witzke Funeral Homes, Inc. 1630 Edmondson Avenue, Catonsville, MD 21228 esella 10 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or reart failure. List only one cause on each life. Approximate Intarval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ENCEPHAZOPATH 9 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown DEMENTIA 24s. Was an autopsy performed? 24b. Ware autopsy findings available prior to DIABETES MEILITUS completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospitat: 150 Inpetient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 DiNatural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide TC Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and dua to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and dua to the cause(s) and manner stated. 29a. Certifier (Check only one 29c. License number 29b. Signature and title of pertifier 29d. Date signed (Month, Day, Year) mehlo D00 41410

Registrar

NORTHWEST 31. Date filed (Month, Day, Year) JAN 28 2000

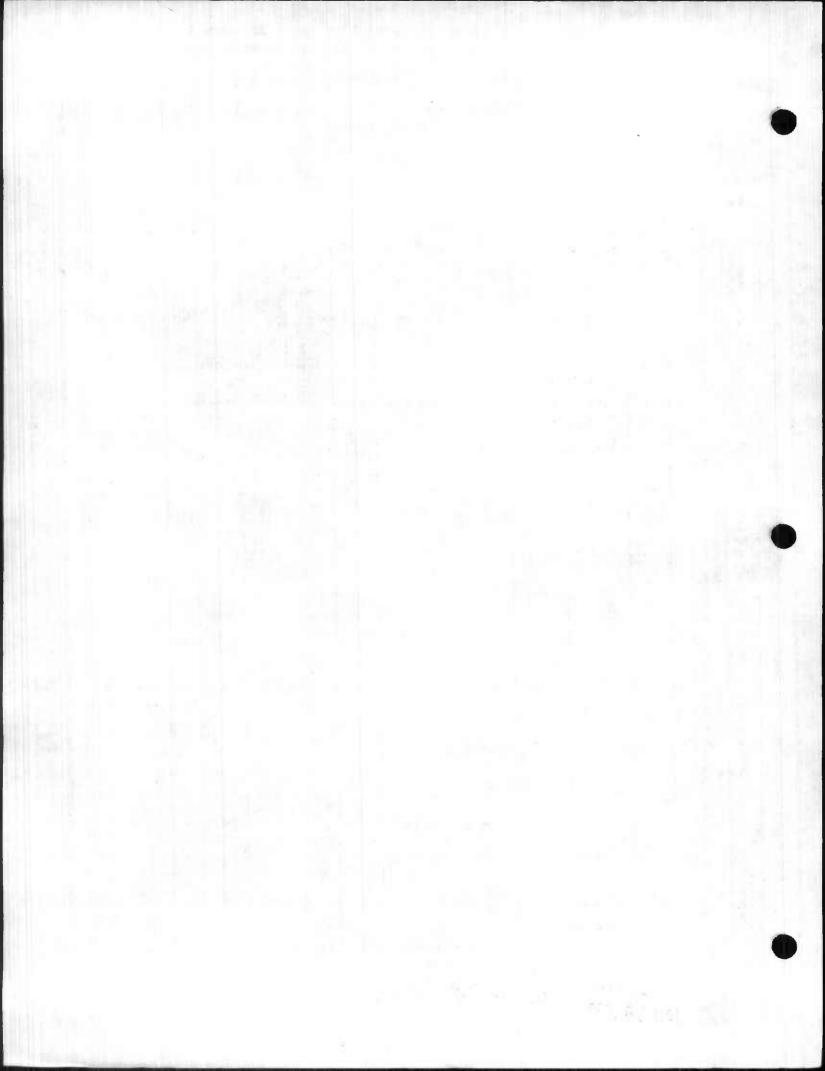
HOSPITAL LENTER RANDAUSTOWN MD

Johnson

- 00-0

m.D

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1061 NO ER P MEHTR



| MALCOLM | | | | Stat | e of | Mary | rland / Department of Health and Menta Certificate of Death | Hygiene |
|----------|-------|--------|-----|------|------|------|--|----------|
| JENNINGS | AMEND | ITEMS: | #23 | PART | I, | 27, | Certificate of Death | Reg. No. |

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| U | 6 | U | 0 | 3 | |

| | Physician |
|---|-----------|
| | /Medical |
| 2 | Evaminar |

1. Decedent's Name (First, Middle, Last)

4a Facility Neme (If not institution, give street end number)

JENNINGS

Days

2. Date of Death Month

23,2000

4c. County of Death

Og. Citizen of What Country?

3. Time of Death 10:56P.M.

BON SECOUR HOSPITAL 5. Social Security Number 12 M 2 F 214 - 70-9772 Usual Residence of Decedent

MALCOM

7. Age (In yrs. last birthdey) If Under 1 Year Yrs.

10c. City, Town or Location

BALTIMORE If Under 24 Hrs. 8. Min Hours

4b. City, Town, or Location of Deeth

8. Date of Birth (Month, Day,

JANUARY

NIA Birthplace (State or Foreign Country)

10d. Inside City Limits

18 Yes 2□ No

Funeral Director

items 23s or 28s-f show

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al Hygiene.

is marked of

Health Hem 27 i

8

Department of Important: If is any injury or o ance.

11led within 72 hours after

Pages 1 and 2 should be

Maryland 21215-0020

Saltimore,

Director

Funeral

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Completed

Be

10a. Siele 10b. County MARYLAND 10e. Street and Number

629 VENUE 11. Marijel Slalus

Wes Decedent Ever In U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:

21229 Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Specify:

14. Raca - American Indian, Black, White, etc.

1 Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced

15. Decedent's Education (Specify only highest grede completed)

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired)

1 □ Yes 20 No

16b. Kind of Business/Industry

Elamantary/Secondary (0-12) 12 TH GRADE

MANUFACTURING CO.

BLAC

17. Father's Neme (First, Middle, Last)

DENNINGS

19b. Mailing Addrass (Street end Number or Rural Routa Number, City or Town, State, Zip Code)

19a. Informant's Name/Ralationship (Type, Print) ANDREA JENNINGS (BROTHER)

629 20b. Place of Disposition (Neme of cemetary, crametory or other place)

VALE AVENUE, BALTIHORE, MD. 21229 20c. Location - City or Town, State

20a. Method of Disposition

1. Burial 2 Cremetion 3 Removal from State

4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Servica Licenses

ARBUTUS CEMETERY 01-29-00 BALTIMORE, MARYLAND 22. Name and Address of Facility JR, FUNERAL HOME H. BROWN JOSEPH 2140 N. BALTIMORE, MD, 2121 N. FULTON AVE.

Date

unce

23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory afrashock, or heart failure. List only one cause on each line.

Approximata Intarval Between Onset and Death

Physician /Medical Examiner

and

the attending physician

usa as the

Physician/Medical Examiner

Be Completed by

Medical Certification: To

ALCOHOL AND NARCOTIC INTOXICATION

Dua to (or as a consequance of)

Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or Injury that initiated events rasulting in death) Last

Immediate Cause (Final disease or condition resulting in death)

Due to (or as a consequence of)

Due to (or as a consequence of)

23b. Did tobacco use contribute to the cause of death? 1 Yaa 2 No 3 Probably 4 Tunknown

24a. Was an autopsy parformed?

24b. Wera autopsy findings available prior to completion of cause of death?

2 No

1 Yas 2 No

25. Was casa rafarred to medical examiner? TXXYes 2□ No

27. Manner of Death

1 Natural

2 Accident 3 Suicide

4 Homicida

5 Pending invastigation

Hospital: 1 ☐ Inpatient 2 💢 ER/Outpatient 3 ☐ DOA 28a. Data of Injury FOMM: Day Year) 1-23-2000 28b. Time of FOUND; 10:56

Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I.

P 28c. Injury at Work? 1 Yes 2 No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Dascribe how injury occurred

6 ☼ Could not be determined 28a Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) RESIDENCE UNKNOWN

26. Place of Death (Check only one)

281. Location (Street and Number of Rural Boute Number BALTIMORE, MD. STRICKER

29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledga, death occurred at tha tima, date and place, and due to the causa(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifie

29c. License number O.C.M.E. 29d. Date signed (Month, Dey, Year) JANUARY 24,2000

30. Name and address of person who complated these of death (ttem 23a) (Type, Print)

THEODORE M.K. 31. Date filed (Month, Day, Year)

111 Penn Street, Baltimore, Maryland 21201 32. Registrar's Signature

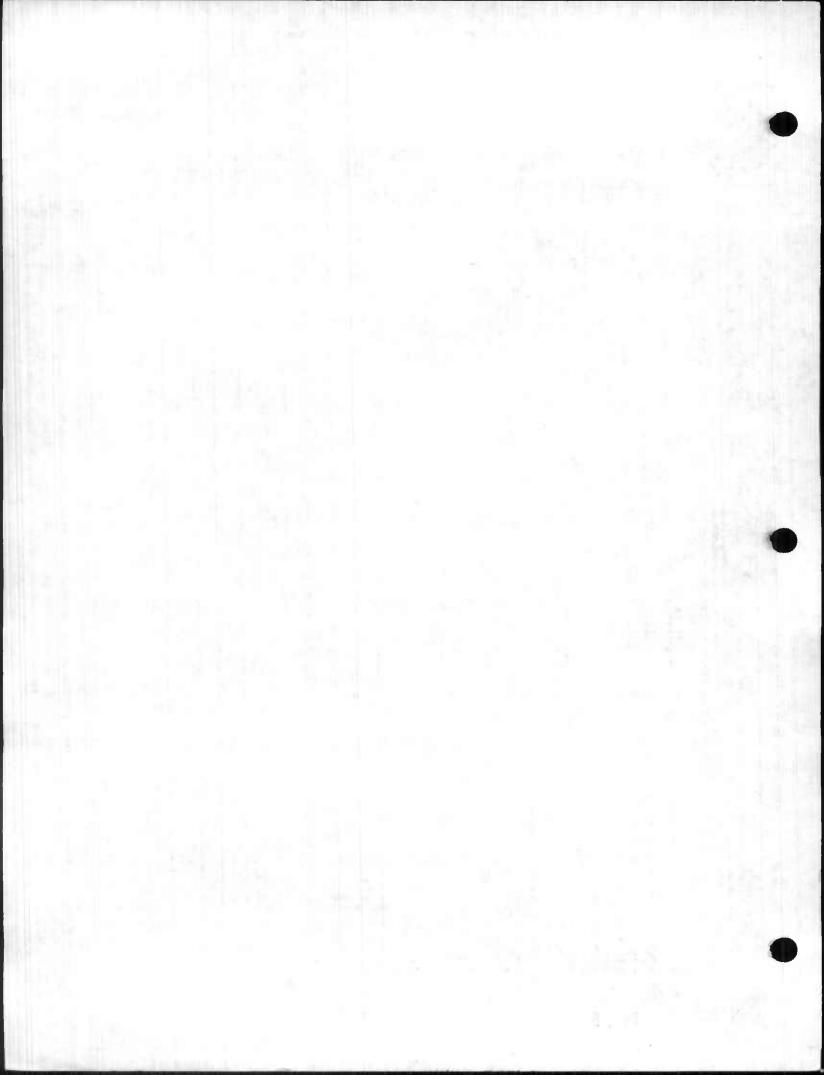
State Registrar

JAN 2 8 2000

ORIGINAL

The law requires that the death certificate be axecuted Box (P.O. Division of Vitai Records.

ours after deeth. eral Director: After this certificate hes been sig filled in by the funeral director, page 2 should b or Attending Physician: To the Hospital of within 24 hours at To the Funeral Discompletely filled in



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 19 2000 **Physician** 5-45 PM Alonzo Janhary Jackson /Medical 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner BALTIMORE FREDERICK VILLA NURSING HOME If Under 1 Year Months Days If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
MAR YLAND 5. Social Security Number 7. Age (In yrs. last birthdey) **Funeral** 1X M 2□ F Hours 705-10-9100 Usuel Residence of Decedent Director the Maryland 10a. State 10b. County 10c. City. Town or Location permit. Pagas 1 and 2 should be filed within 72 hours efter death with the Marylan Department of Health and Mantal Hygiana. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, its Medical Examiner mest be notified at 10d. Inside City Limits 18 Yes 2□No Director MARYLAND 10e. Street end Number 10g. Citizen of What Country? 4503 FIELD ROAD USA Funeral 12. Was Decedent Ever in U,S. Armed Forces?

1 XYes 2 No//- 26-43 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Raca - American Indian, Black, White, etc. 1 Never Married 2 Married If Yes, Give Yeer or Detes: 01-04-46 Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: BLACK þ 3 ₩idowed 4 Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) LABORATORY WORKER ABERDE 12 HIGRADE ABERDEEN PROVING GROUND 17. Father's Name (First, Middle, Last) 10 JAMES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SALLY COLBERT (STEP-DAUGHTER 4503 WAKE FIELD RD, *B BALTI MORE, MD. 212/6

20a. Method of Disposition

10 Rurial 2 Cremation 3 Removal from State

20b. Place of Disposition (Name of cametery, crematory or other place) Burial 2 Cremation 3 Removal from State CROWNSVILLE CEMETERY OF-25-00 CROWNSVILLE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility H. BROWN JR. FUNERAL HOME Pass, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest,

Approximete Approximete Interval Between Onset and Deeth **Physician** /Medical Immediate Ceuse (Final BRONCHO PNEUMONIA one beek disease or condition resulting in death) Examiner CEREBRO WASCULAR ACCIDENT Examiner Lean bunal-transit Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Last Due to (or as e consequence of) pue attanding physician for usa es tha buna P.O. Box 68760 Physician/Medical Due to (or as a consequence of): Part II. Other algorificant conditions contributing to death but not resulting in the underlying ceuse given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Scizures Records, 24b. Were autopsy findings available prior to completion of cause of death? Completed 24e. Wes an autopsy performed? 1 Yes 20 No 1 Yes 2 No Division of Vital Be 25. Was cese referred to medicel examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA illed in by tha funeral 28c. Injury at Work? 27. Manner of Death 28e. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how Injury occurred Certification: Aftar To the Hospital or Attending I within 24 hours eftar daath.

To the Funeral Director: Aftar 5 Pending investigation 1 Neturel 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Phyalcian: To the best of my knowledge, deeth occurred et the time, date and plece, end due to the cause(s) end manner as steted.
2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date and piece, end due to the ceuse(s) and manner steted. Medical 29a. Certifier Somplataly (Check only one) 29d Date signed (Month, Day, Year)
Tanky 21. 29b. Signature and transf certifil 29c. License number D. 20469 30. Name and address of person who completed ceuse of deeth (Item 23e) (Type, Print) DRIVE. # 100: Ellicate City; MD. 21042

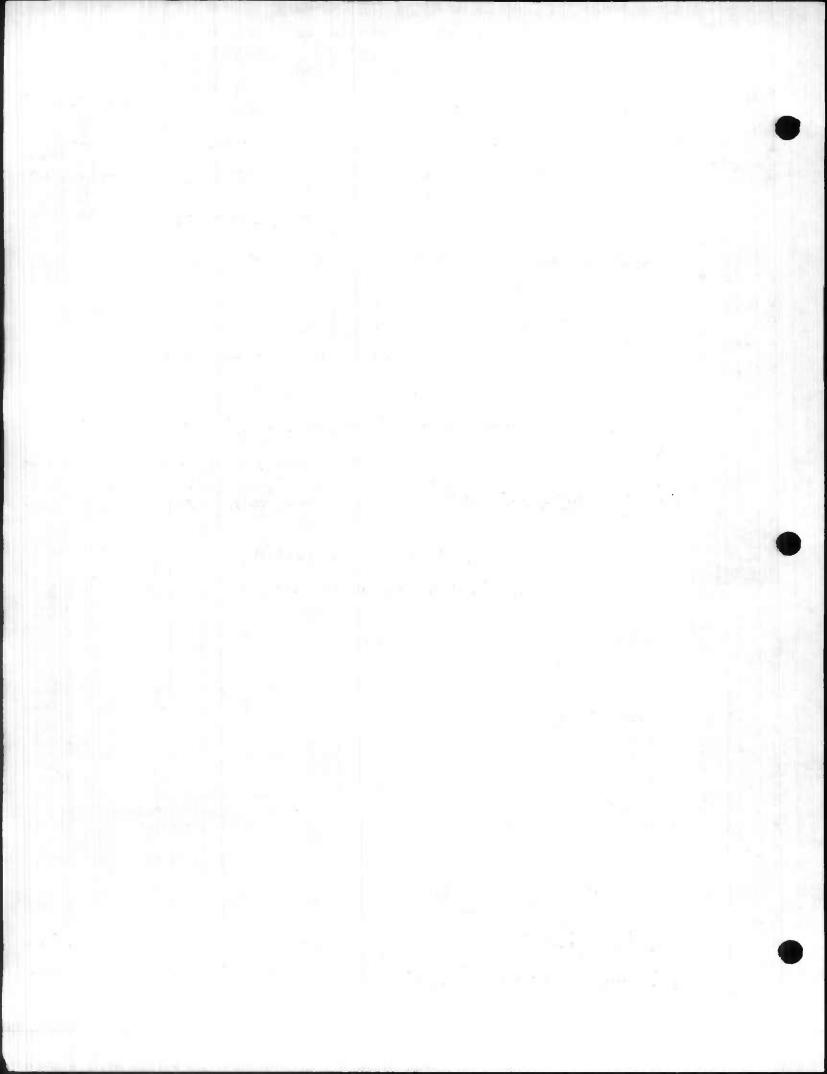
State Registrar

Hegistrar JAN 2 8 2000

31. Date filed (Month, Day, Year)

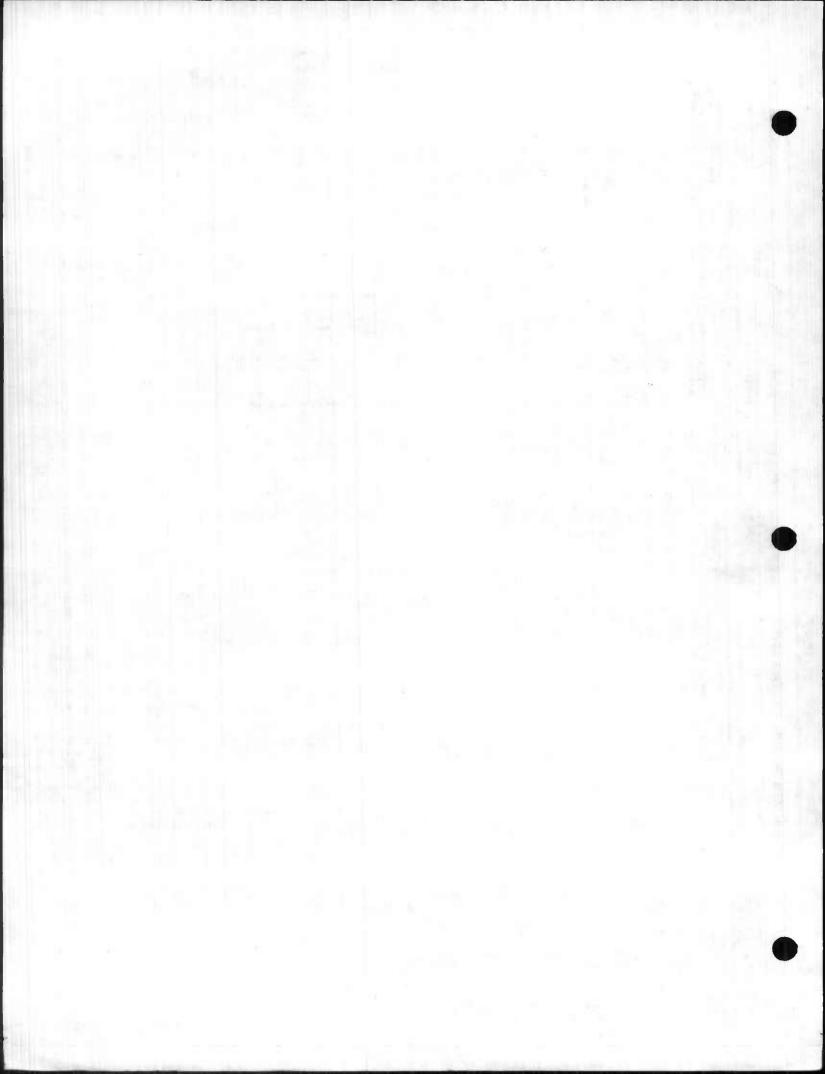


& Sparks



State of Maryland / Department of Health and Mental Hygiene 0 2035

| _ | Decedent's Name (First, Middle, Last | net. | Ce | ertificate | of Death | 2. Date of Dea | leg. No. | UZUJJ | | |
|---|--|--|---|--|---|---|--|--|--|--|
| Physician | The second secon | • | | | | Month | Day | Year | | |
| /Medical | Eric | Jordan | | | Tu es e | Jan. | | 2000 11:15ar | | |
| Examiner | 44 Facility Name (If not institution, give 4401 Bayonne | · · | | | Baltin | | 4c. County | of Death | | |
| Funeral Director | 5. Sociel Security Number 6. S 220-74-0748 x 1 Usuel Residence of Decedent | 7. Age (In 40 | yrs. last birthday Yrs. | Months D | ear If Under 24 Hi ays Hours Mi | | Year) -59 | Birthplace (State or Foreign Country) M D | | |
| B m | 10a. State 10b. County | 10c | . City, Town or L | ocation | | | | 10d. Inside City Limits | | |
| 28a-f sh notified a | MD NA | | Baltim | ore | | N∏Yes 2□1 | | | | |
| 5 g 🛱 | 10e. Street and Number 4401 Bayonne | Avenue | | 10f. Zip Co 212 | | 1 | 0g. Citizen of W USA | hat Country? | | |
| ar, or Nema 23s Examiner must by Funeral | 11. Marital Stetus 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. Wes Decedent Ever Armed Forces? 1 ☐ Yes 2☐No If Yes, Give Year or Dates: | in U,S. 13. | | of Hispanic Origin? Cuban, Mexican, Pue No Specify: | (Specify Yes or No- irto Rican, etc.) | | e - American Indian, k, White, etc. | | |
| ted bet | 15. Decedent's Ed | ucation | 16a. Deci | edent's Usual O | ccupation | | 16b. Kind of Bu | | | |
| N. the Medical Completed | (Specify only highest gra- Elemantary/Secondary (0-12) | de completed) College (1-4or 5+) | | | one during most of w etired) | orking | | | | |
| E E | 11th Grade | NA | Dis | abled | | | Disab | led | | |
| Be C | 17. Father's Name (First, Middle, Last) | | | | 18. Mother's N | ame (First, Middle, | Meiden Surnam | е) | | |
| To B | Skiro J | ordan | | | Thelm | a C | reight | on | | |
| - | 19a. Intormant's Name/Ralationship (7 | vne Print) | 19b Mai | ling Address (S) | reet and Number or I | | | | | |
| er trau | Robert Jord | | | | tt Place | | | 0469 | | |
| ě | 20a. Method of Disposition | | b. Plece of Disp | | | Date | | City or Town, State | | |
| ury or o | 1 ☑ Burial 2 ☐ Cremetion 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify | | Baltim | | metery C | 1-28-20 | 00 Ba | ltimore, MD | | |
| any in | 21. Signeture of Funerel Service Licensee 22. Name and Address of Facility Baltimore, Maryland 2120 WM.C. March FH 1101 E. North Avenue | | | | | | | | | |
| sician | 23a. Pert 1. Enter tha disease, or combon shock, or heart tailure. List only | lications that caused the cone ceuse on each line. | death. Do not er | nter tha mode of | dying, such as cardi | ac or respiratory arr | est, | Approximate Interval Between Onset end Deeth | | |
| ledical | Immediate Cause (Finel disease or condition | MY | OCAN | D 1 AT | - INF | AN CT / | OW | SAME | | |
| niner | resulting in death) | Dua i | to (or as a conse | | 77017 | (100) | | | | |
| je L | | END | CTALE | | VAZ D | 15 EMT | E | | | |
| tal-transit Examiner | Sequentially list conditions, | D | lo (or as a conse | | y , - y | 77/13 | | | | |
| s the bur | | | | | | | | | | |
| | | d | | | | | | | | |
| sici | Part II. Other algnificant conditions co | ntributing to death but not | th but not resulting in the underlying cause give | | | 23b. Did to | obacco use con | tribute to the cause of death | | |
| igned by the attending be detached for use a by Physician/M | | | | | | 104 | 20 No | 3 Probably 4 Unknow | | |
| should should | | | | | | 24a. Was a perfor | in autopsy med? | 24b. Were autopsy tindings available prior to completion of cause of death? | | |
| s certificate has director, page 2 To Be Comp | | | | | | 1 🗆 Y | as 2 No | 1 ☐ Yes 2 ☐ No | | |
| certificate has rector, page 2 Be Comp | 25. Was casa raferred to medical | | | | 26. Place of D | eeth (Check only or | ne) | | | |
| To B | examiner? 1 D Yes 2 □ No | Hospital: | 2 ER/Outpatie | ent 3 DOA | Other | | p | er (Snecity) | | |
| After thi funeral flon: 1 | 27. Manner of Death 1 DNatural 5 Pending 2 Accidant investigation | 28a. Date of Injury (Month, Day Yea | 28b. Time | - | tnjury at Work? | 7 | 5 Presidence 6 Other (Specify) Describe how injury occurred | | | |
| To the Funeral Director: After thi completely filled in by the funeral Medical Certification: 1 | 3 Suicide 4 Homicida 6 Could not be determined | 28e. Place of Injury - A building, etc. (Sp | | treet, tactory, of | lice | 28f. Location (S City or Town | treet and Number, Stete) | er or Rural Route Number, | | |
| Funer letely fill dicai | 29a. Certifier (Check only one) 1 ☐ Certifying Phy | raician: To the best of my lnar: On tha basis of axan end manner stated. | knowledge, dea nination and/or in | th occurred at the nvastigation, in r | ne time, date and pla my opinion, death oc | ce, end due to the courred at tha time, d | ause(s) and ma lata and place, a | nner as stated. and due to the cause(s) | | |
| To the comple | 29b. Signature and title of certifier | | | 29c. Li | cense number | 2 | 9d. Data signed | i (Month, Day, Year) | | |
| 10 | 010 | 1 | ^ | | 111272 | 4 | Descri | V. 170 m | | |
| , | 30. Name and addrass of person who c | ompleted causa of death (| Item 23a) (Type | , Print) | 17525 | T | 34400 | 2 / 2000 | | |
| | DAVID 51LVB | r vo, 34 | t11 180 | INK S | 1 B41- | TIMORE | , Md | 121224 | | |
| State Registrar | JAN 2. 8 | 2000 Sa. Registrar's Si | AND | 19 de | souls! | | | | | |



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Day 23 Month Year **Physician** Ovanna Jacksor (-2000 1602 01 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hookens porcuo Med we If Under 24 Firs N/A If Under Birthplaca (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number Months Days Hours 1□ M 2☑ F 67 212-28-8901 June 19,1932 Virginia Usual Rasidence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 No Director Maryland N/A Baltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5020 East Biddle Street United States 21205 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Nevar Married 2 Married 1 Yes 2 No Specify: þ Specify 3 € Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 8 Years Inspector Plastic Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumama) Be Bobby W. Argabright Burlie A. Doran 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Mrs. Tylaine Lengrand (Daughter) 5017 East Biddle Street Baltimore, Maryland 21205 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State etery, crematory or other place) Buriai 2 Cremation 3 Removal from State Gardens of Faith Cem. 1/27/00 4 ☐ Donation 5 ☐ Other (Specify) Rosedale, Maryland 21. Signature of Funeral Servica Licansee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. Zillia 23a. Part1. Entar tha disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, ahock, or heart failura. List only one cause on each line. Dundalk, Maryland Approximate Interval Between Onset and Death immediate Cause (Final agstrointestinal bleeding one week disease or condition resulting in deeth) Physician/Medical Examiner esophageal and gastric varices Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): al hypertension
Due to (or as a consequence of): portal disease IVCY Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Yes coronary artery disease Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? diabetes mellitus 1 Yes 1 ☐ Yes 20 No 2 No 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Hospitel: Other: 4 Nursing Home 5 Residence 8 Other (Specify) Medical Certification: To 1 Danpatient 2 ER/Outpetient 3 DOA 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Netural 2 Accident 5 Pending 1 Yes 2 No investigation 6 Could not be determined 3 Suicide 28e. Pleca of Injury - At home, ferm, atreet, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signatura and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number

To the Hosp within 24 hou To the Fune completely fil 9

DHMH 16 Rav 6/95

Funeral

Director

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23a or

Berns

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Hygiene.

Pages 1 and 2 should be nent of Health and Mental

permit. Pages 1 and 2. Department of Health as Important: If them 27 Is any Injury or other trait.

Physician /Medical

Examiner

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should be det

certificate

ini or Attending Physician: These after death.

al Director: After this certificate ed in by the funeral director, pa

Hospital 24 hours

filled in by

The law requires that the death certificata be executed

P.O. Box 68760.

Records,

Division of Vital

.

filed within 72 hours after

altimore, Maryland 21215-0020

State Registrar

31. Date filed (Month, Day, Year)

lerilyn R Scott

Johns Hopkins Hospital 601 North Caroline Street 32. Registrar's Signature

January 23, 2000

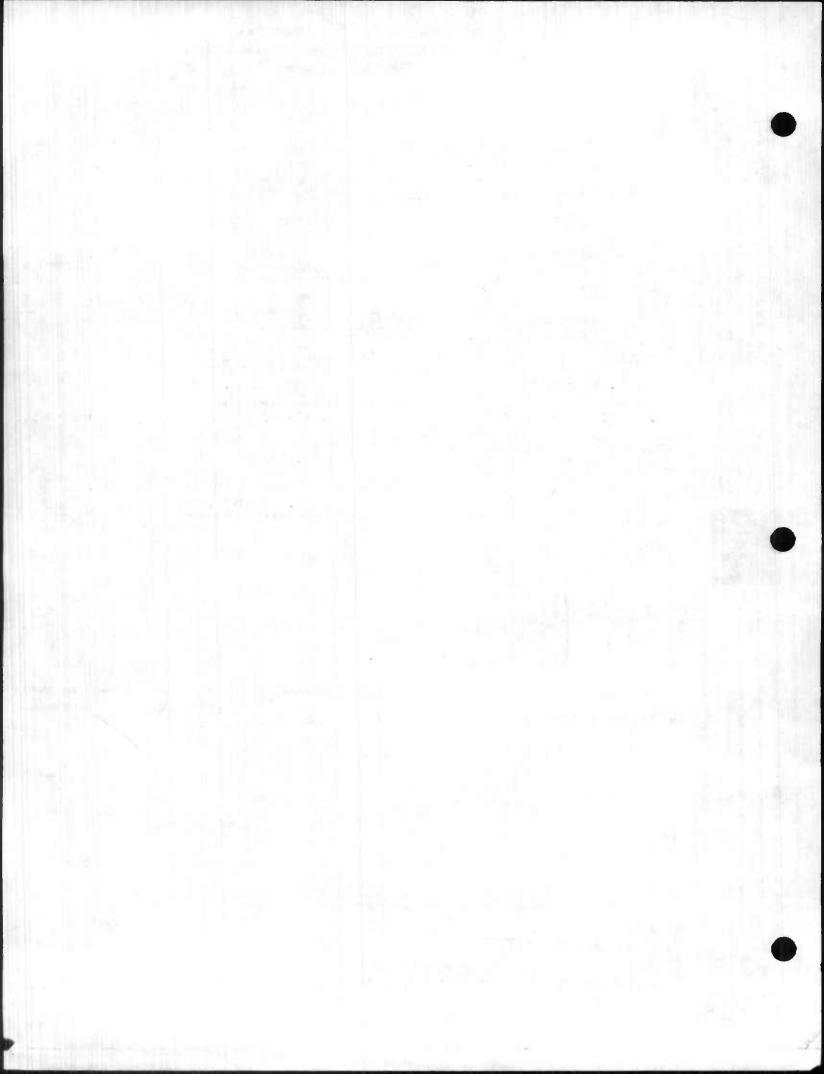
Internal Medicine

Bulhmore, Muruland

JAN 2 8 2000

Serely R/ Scott

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Please Type or Print in Black indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene \(\) Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Date of Death 3. Tima of Death Month Year **Physician** 1818 01 Jones 2000 /Medical 4a Facility Name (I not Institution, give street and number) 4h. City. Town, or Location of Death 4c. County of Death Examiner MARY LAND University Baltimore Baltimore 6. Sex If Under 1 Yaar | If Undar 24 Hrs. Birthplace (State or Foreign Country) 8. Data of Birth (Month, Day, Year) 5. Social Security Number 7. Aga (In yrs. last birthday) Months Days Hours Min. 1 M 2 F 64 2-19-32-2947 Yrs. Usual Rasidence of Dacedent 10a. Stata 10b. County 10c. City, Town or Location 10d. tnside City Limits Baltimore 1 Yas 2 No Ma NA Director 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? Street . S. A 21218 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian, 11 Marital Status 12. Was Decedent Ever in U,S. Armed Forcas? Black White atc. 1 ☐ Yes 2 ☑ No If Yas, Giva 1 Nevar Married 2 Married 1 Yas 2 No Specify: à Black 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use ratired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highast grada completed) Security Social College (1-4or 5+) Elemantary/Secondary (0-12) Security 12 thyrade Guard 17. Father's Nama (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be Coates Vincent Katie 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 7838 H1/1284 Daughter 3a Ho Md 21244 Cornerstoneway 20b. Place of Disposition (Nama of cemetery, cramatory or other place) 20a. Mathod of Disposition Date 20c. Location - City or Town, Stata 1 Burial 2 Cramation 3 Ramovel from Stata Himore National 4 ☐ Donation 5 ☐ Other (Specify) Cery 12000 21. Signature of Funguri Sovice Licensee 22. Name and Addrass of Facility Wes7 March F. H Ba (40, red 21215 Avenue 4300 utibash Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. Approximate Interval Between Onset and Death 4 day Immediate Causa (Final Cerebro Vascular diseasa or condition rasulting in death) Examiner ENDOCARDITIS mitra Sequentially list conditions, if any, leading to immediata cause. Entar Undarlying Cause (Disease or injury that initiated events rasulting in death) Last Dua to (or as a consequenca of): Physician/Medical Dua to (or as a consequence ot): Part II. Other algorificant conditions contributing to death but not resulting in the underlying causa givan in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown End . Stage Renal Disease 24b. Wera autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 Yas 2 No Be 25. Was casa rafarred to medicat axaminer? 26. Placa of Death (Check only ona) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Yes 2 No 1 Inpatiant 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28h Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 8 Could not be determined 3 Suicide Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homicide

Records, P.O. Box 68760, Division of Vital To the Hospital or Attanding Physician: within 24 hours after death.

To the Funeral Director: After this cartifica completely filled in by the funeral director, i

Funeral

Director

28a-f ahow

or items 23a or

"natural"

I filed within 7 I Hygiene.

permit. Pages 1 and 2 should be filled with Department of Heelth and Mentel Hygien Important: if Item 27 is marked other that any Injury or other traumets.

Physician

/Medical

Examiner

attending physician and for use as the burial-transit

8

certificate

Baltimore, Maryland 21215-0020

traumetic avent, the Medical Examiner must be notified at

State Registrar

DHMH 16 Rev 6/95

ERIL 31. Dete filed (Month, Day, Year) JAN 28 2000

30. Nama and addrass of person who completed causa of death (item 23a) (Type, Print)

SHAW

29b. Signatura and titla of country

29a. Certifier (Check only one)



Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and mannar as stated.

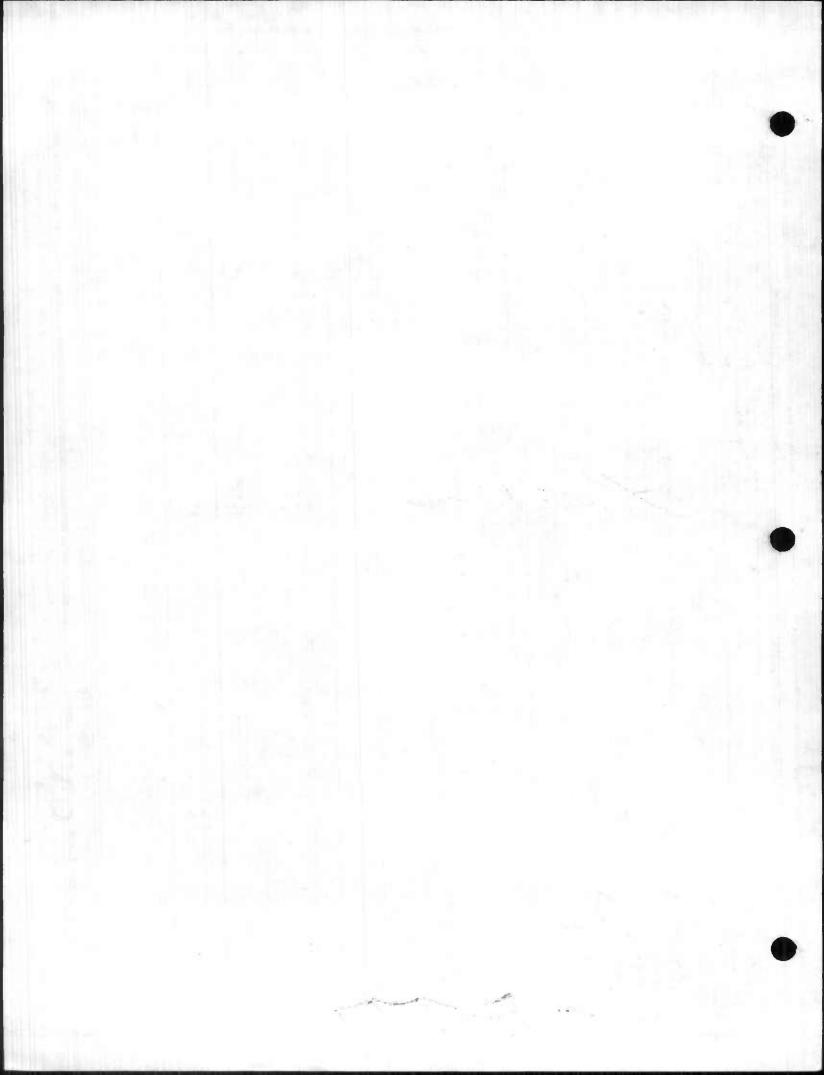
[2 Medical Examiner: On the best of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end mannar stated.

29c. Licansa number

12436

TONSHILLE

29d. Data signed (Month, Day, Year)



Examiner Box 68760, Division of Vital Records, P.O.

The law requires that the death certificate be executed nding physician and use as the buriel-transit signed by the certificate has or Attending Physician: this After t death. I Director: A To the Hospital or Att within 24 hours after of To the Funeral Direct completely filled in by

Physician

/Medicai

Examiner

Director

Funeral

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Completed

Be 2

Examiner

Physician/Medical

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Completed

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Certification:

Medical

Funeral

Director

item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after Depertment of Health and Mental Hygiene. Important: If Item 27 is merked other than "natural, or ite any Injury or other traumatic event, the Mental Earning any Injury or other traumatic event, the Mental Earning.

Physician /Medical

death

Maryland 21215-0020

Baltimore,

State Registrar

DHMH 16 Rev 6/95

31. Dete filed (Month, Day, Year)

Rm 206

32. Registrar's Signature

30. Name and address of person who completed ceuse of death (item 23a) (Type, Print)

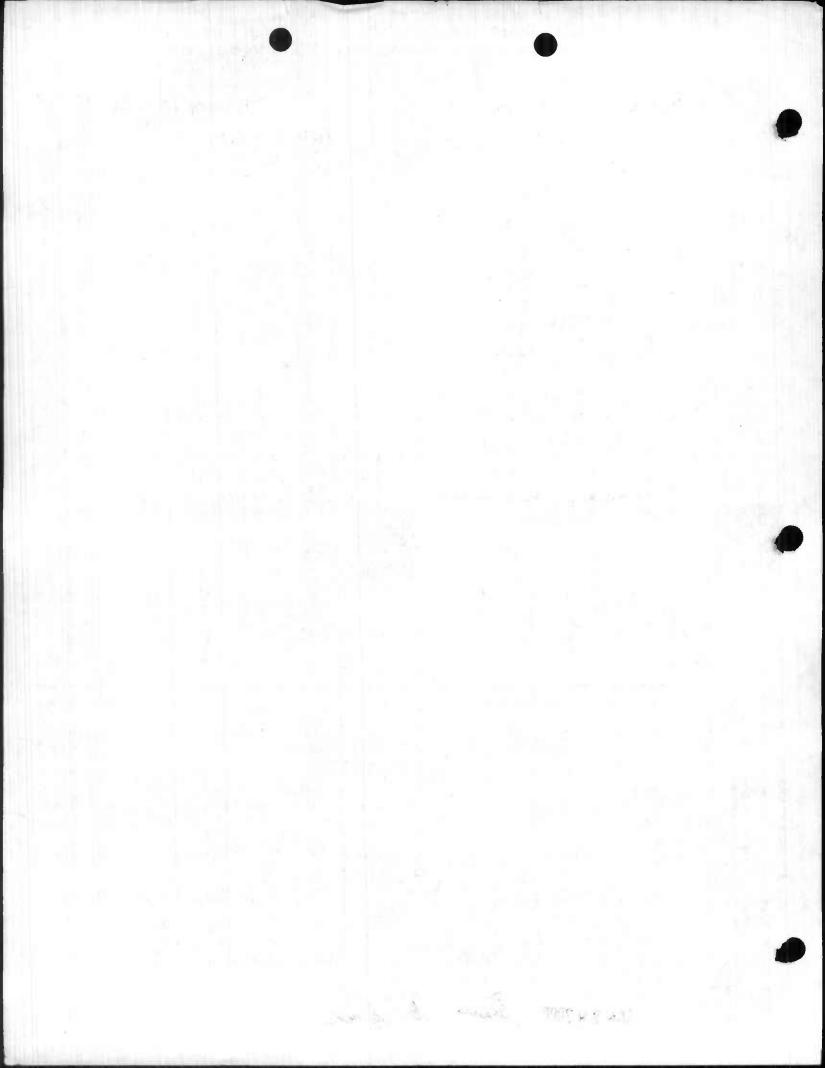
Gutan street

031865

22/2000

821

Mien-D Kirry, mo



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 2 1 3 9 Item: 20a per F.H G-779 1/28/2000 reb Certificate of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Deta of Death Month **Physician** January 23,2000 Johnson Harold /Medical 4c. County of Death 4b. City, Town, or Location of Deeth 4a Facility Nama (If not Institution, giva street and number) Examiner Baltimore City 5. Social Security Number Dital If Undar 1 Year If Undar 24 Hrs. 7. Age (In yrs. last birthday) Birthplaca (Stata or Foraign Country) 8. Data of Birth (Month, Day, Year) **Funeral** Days 1X M 2□ F 216-34-5140 **Director** 62 37 M.D. 09 11 Usual Rasidanca of Decedant the Maryland r 28a-f ahow 10a. Stata 10b. County 10c. City, Town or Location 10d. insida City Limits fx as 2 □ No Director Baltimore NA MD 10e Street and Number 10f. Zip Coda 10g. Citizan of What Country? d 2 should be filed within 72 hours after death with thand Mental Hygiene.
7 is marked other than "natural", or itema 23a or itemmatic event, the Medical Evan her must be or 21201 111 Park Ave Apt 714 U.S.A. Funeral 12. Wes Dacedant Ever in U,S. Armed Forces? 1 ☐ Yas 27.2No If Yes, Giva Yaar or Datas: 13. Wes Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14 Raca - American Indian Bleck, Whita, etc. Nevar Married 2 Married altimore, Maryland 21215-0020 1 Yas 2 No Specify: Specify: þ Black 3 Widowed 4 Divorced Completed 15. Dacedent's Education (Specify only highest grade completed) 16e Decedant's Usual Occupation 16b Kind of Business/Industry (Giva kind of work done during most of working lifa. DO NOT usa ratired) Elementary/Secondary (0-12) Collega (1-4or 5+) Baltimore City School Teacher 12th grade 6yrs+ 17. Fether's Name (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maidan Surnama) . Pages 1 and 2 should be fill ment of Health and Mental Hant: If item 27 is marked oth lury or other traumatic even 86 Georgian Marley Joseph E. Johnson Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 3424 Christopher Ct, Baltimore Md Linda Ingram-Niece 20b. Placa of Disposition (Nama of cematary, cramatory or other placa) 20c. Location - City or Town, State 20a. Method of Disposition Important: If it any injury or c poce. 2 Cramation 3 □Ramoval from State Metro Crematory Inc. 1/26/2000 Baltimore, Md 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signatura of Funaral Sarvice Licenses 22. Nama and Addrass of Facility March F/H West 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21215 Baltimore Md Approximate Interval Between Onsat and Death Physician Immadiata Causa (Final diseasa or condition rasulting in daath) /Medical eumonia Examiner Due to (or as a consequence of). Examiner ticiency Syndrome mmune the death certificate be executed physician and the burial-transit Sequantially list conditions, if any, leading to immadiata causa. Enter Underlying Causa (Disaase or Injury that initiated evants rasulting in daath) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Dua to (or as a consaquanca of): as esn o signed by the a Part II. Other significant conditions contributing to death but not resulting in the undariying causa givan in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown that P 24b. Wara autopsy findings available prior to 24a. Was an autopsy performed? Completed complation of causa of daath? The law cartificate has birector, page 2 s 2 12 No 1 Yas 2 No 25. Was casa rafarred to madical axaminar? Be 26. Place of Death (Check only ona) Hospital: Othar: 4 Nursing Homa 5 Residence 8 Othar (Specify) 1 Yas 2 No 1 1 Inpatient 2 2 ER/Outpatient 3 DOA Shis funeral 28a. Data of injury (Month, Day Year) 27. Manger of Death 28b. Tima of 28c. injury at Work? 28d. Dascribe how injury occurred Certification: After Attending 1 Watural 5 Panding Invastigation death. 1 Tyas 2 No 2 Accidant after death Director: 6 Could not be detarmined 3 ☐ Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicide ò filled in 24 hours a 29a. Certifier 11 certifying Physician: To tha best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated. Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the F within 2 29b. Signatura end title of curtified 29c. Licansa number 29d. Data signed (Month, Day, Year) 30. Nama and addrass of person who complated causa of death (Item, 23a) (Type, Print) YRabhakar General m.D. 40 maryland 31. Date filad (Month, Day, Year) 32 Registrar's Signatura

JAN 2 8 2000

Registrar

OHMH 16 Rav 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMENDED ITEM #5 PER FH G780 2/2/2000 AH Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Robert Edward Johnson 22 2000 /Medica 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Levindale Hebrew Geriatric Center & Hospital **Baltimore Baltimore City** If Under 1 Year Months Days If Under 24 Hrs. 5. Social Security Number 419-05-9836 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 M 2 F 85 November 18, 1914 Alabama Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Directo Maryland Howard Ellicott City 280-1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 21042 3574 Lowlen Court U.S.A natural', or Nerns 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U,S. Armed Forces? 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give 1968 Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White ğ 3 Widowed 4 Divorced 1973 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry U. S. Air Force College (1-4or 5+) Soldier 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental mportant: If Item 27 is marked Robert Edward Johnson Evie French Pages 1 and 2 should 10 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a 3574 Lowlen Court Ellicott City, Maryland 21042 Ms. Frances Mae Johnson Wife 20b. Place of Disposition (Name of 20a, Method of Disposition 20c. Location - City or Town, State netery, crematory or other place) Arlington National Cemetery 8 1 Buriel 2 Cremation 3 Removel from Stete 4 Donation 5 Other (Specify) 01/27/2000 Arlington, Virginia 21. Signature of Funerel Servica Licenses 22. Name and Address of Fecility Slack Funeral Home, P.A. M01204 3871 Old Columbia Pike Ellicott City, MD 21043 23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Box 68760, Physician/Medical Due to (or as a consequence of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown brilletion Records, À 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy 1 Yes 2 No 1 Yes 2 No certificate Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director; to Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manper of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Netural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide edical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted. (Check only one)

State Registrar

JAN 28 2000

29b. Signature end title of certifier

31. Dete filed (Month, Dey, Year)

32. Registrar's Signeture

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

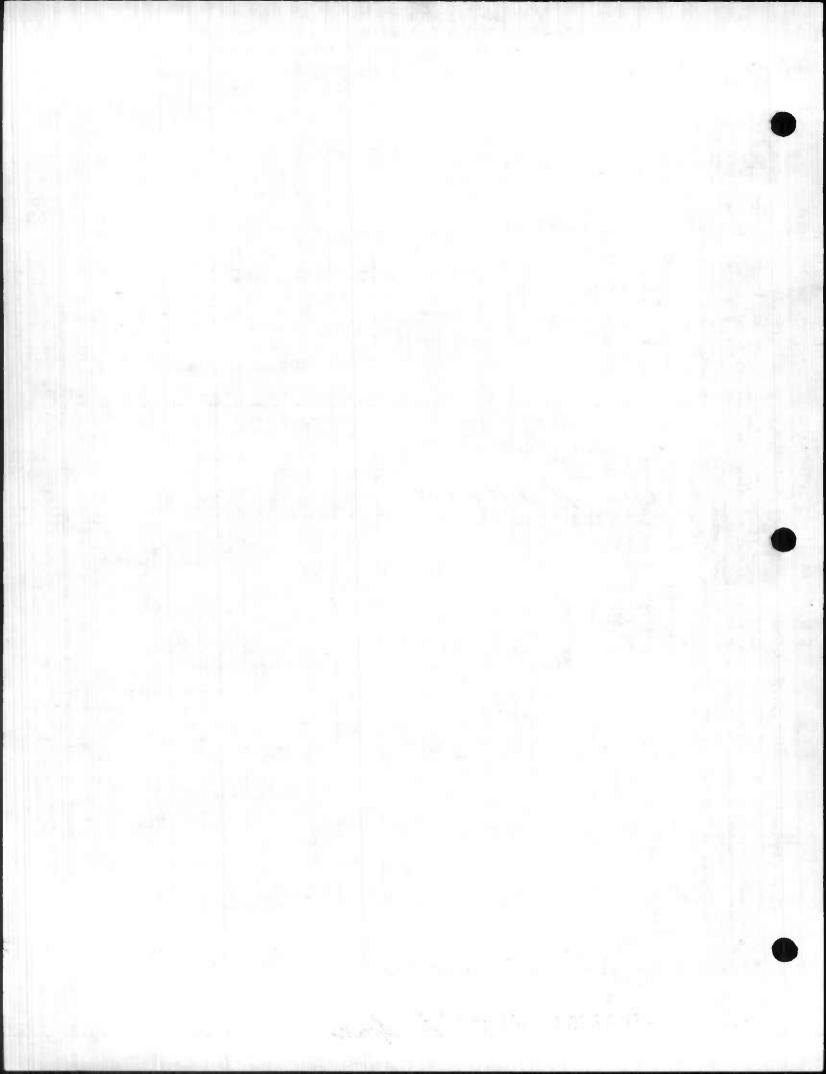
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B. Sports

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29c. License number

Ivadere aux, Balhimore

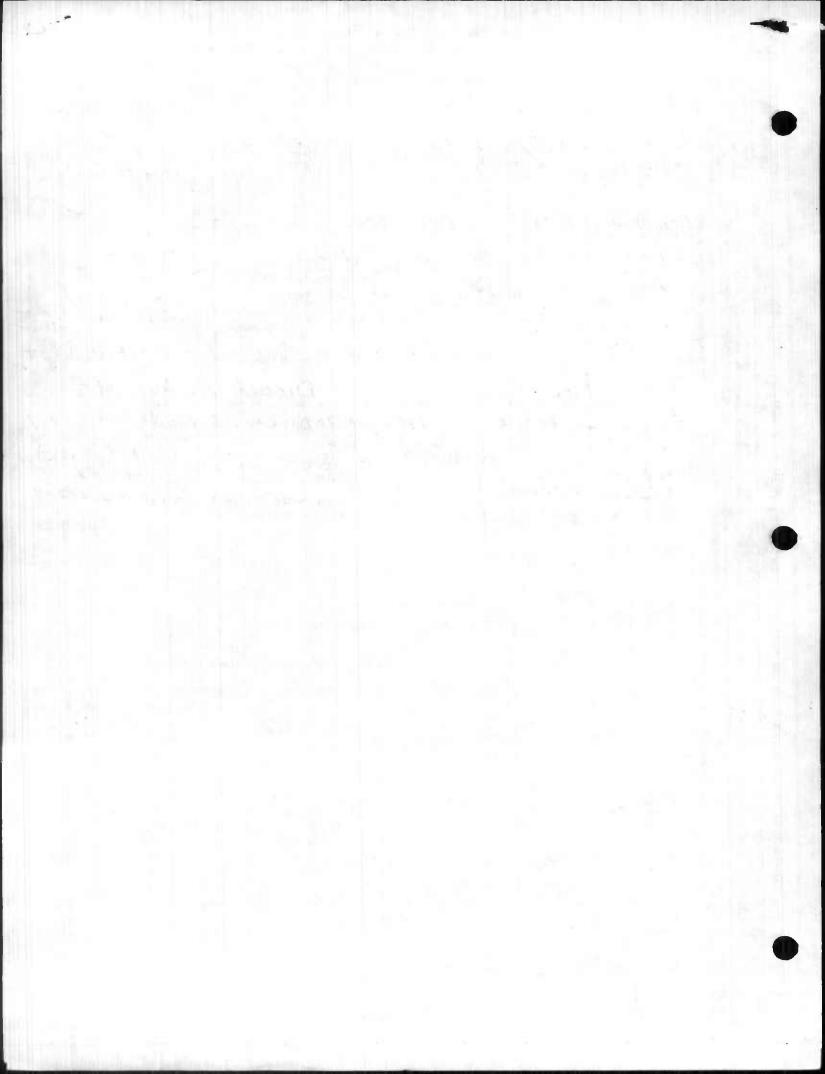


Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decepant's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Day Month **Physician** 20 ENE 2000 6:46 AM 0 /Medical 46. County of Death 4a Facility Nama (If not institution, give street and number, 4b. City. Town, or Location of Death **Examiner** SAMARITAN Jumber 6. Sex TO SPITA

ga (In yrs. last birthday) MORE 000 If Under 1 Yaa 5. Social Security Number 8. Data of Birth (Month, Day, 9. Birthplace (State or Foreign Country) **Funeral** Days Months -16-8183 10M 20 F Director MAR Usual Rasidance of Decedant with the Menylend 10a. State 10b. County 10c. City, Town or Location tiem 27 ie marked other than "natural", or fema 23a or 28a-f ahow other traumatic event, the Medical Examiner must be inclined at 10d. Inside City Limits 12 tes 2 No Director MARY lAnd moRE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2 100 death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes. specify Cuban, Mexican, Puerto Rican, etc.) 14. Race 12. Was Decedent Ever in U,S. Armed Forcas? 11. Marital Status pernit. Pages 1 and 2 should be filed within 72 hours after Department of Health end Montal Hygiene. Important: if Nem 27 is marked other than "natural", or its any injury or other traumatic event, the Manter Exercises. Black, White, etc. 2 Married 1 Yas 2 0 No altimore, Maryland 21215-0020 1 Yes 2 No Specify: f Yas, Giva λq 3 ☐ Widowed 4 ☐ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Store Elamentary/Secondary (0-12) Coilege (1-4or 5+) 17. Fathar's Nama (First, Middla, Last) ma (First Middle Maiden Sumame) Be DEENE 2 BNNA 19a, Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) North bour 3Alto, Md. 21239 EWIS 904 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 3 Ramoval from Stata ROOKLU 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatura of Funaral Sarvice Licenses BAHO. Md 21229 4101 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest shock, or heart failure. List only one cause on each line. Approximeta Intervat Between Onset and Death **Physician** /Medical Immediata Causa (Final Corm bease disaasa or condition rasulting in death) Examiner Examiner ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Sequentially list conditions, if any, leeding to immadiata causa. Enter Underlying Cause (Disease or injury that initieted events rasulting in death) Last Due to (or as a consequence of) certificate be axec Records, P.O. Box 68760, lesebou vage Physician/Medical Due to (or as a consequence of): Disease Part II. Other algnificant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy certificate has 1 Yes 20 No 1 ☐ Yes 2 ☐ No Division of Vital director, 25. Was case rafarred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yas 2 No 1 Inpatient 2/DER/Outpatient 3 DOA After this filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Mannar of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Hospital or Attending 5 Pending invastigation 1 Watural To the Hospital or Attendar within 24 hours after death. To the Funeral Director: A completely filled in by the fi death. 1 Yes 2 🗆 No 2 Accident 6 Could not be datarmined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28a. Pleca of Injury - Al home, farm, street, factory, office building, atc. (Specify) 4 HomicIda To Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

Use Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29s. Certifier (Check only onel 29b. Signature and title of certifier 29c. License number 29d. Data signed (Month, Day, Year) 31464 21 0 May 30. Nama and addrass of person who complated causa of daath (Item 23a) (Type, Print) Balt. mD Smite HASHMI 82 Entono N 31. Data filed (Month, Day, Year) 32. Registrar's Signature State JAN 2 8 2000 Registrar

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Daath 3. Time of Deeth **Physician** Month William Joseph Koppleman 4:30 AM 24 2000 4c. County of Death 4b. City, Town, or Location of Death /Medical 4a. Fecility Nama (If not institution, giva street end number) Examiner If Under 24 Hrs. 8. Date of Bir NORTH A
5. Social Security Number ARUNDEL HOSPITAL ANNE ARUNDEL 8. Date of Birth (Month, Dey, Year) Jan. 12, 1910 if Under 1 Yaar 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Maryland **Funeral** Months Min. 1**⊠** M 2□ F Days Hours Director 215-09-7118 Usual Residence of Decedent death with the Marylend 10e. State 10b. County 10c. City, Town or Location Rems 23a or 28a-f show instrinust be notified at 10d. Inside City Limits Director 1 ☐ Yes 2 No Maryland Anne Arundel Pasadena 10e. Street end Number 10f. Zip Code 10g. Citizan of Whet Country? Completed by Funeral 615 Riverside Drive 21122 U.S.A. 11. Marital Status 12. Wes Decedent Evar in U,S. Armed Forces? 13. Was Decadent of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puerto Rican, etc.) 14. Rece - American Indien, OPPLEMAN -William traumatic event, the Medical Examiner. Black, White, etc. 1 Never Merried 2 Merried 1 ☐ Yes 2 M No If Yes, Give Year or Detes: 6 1 ☐ Yes 2 No Specify 3 ☐ Widowed 4 ☐ Divorced White 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry permit. Pages 1 end 2 should be filed within 7.
Department of Heelth and Mental Hygiene. Important: If Item 271s marked other than "na any Injury or other traumatic event, the second." Elementery/Secondary (0-12) College (1-4or 5+) N/A Welder Olin Chemical Company 17. Father's Name (First, Middle, Last) 18. Mothar's Neme (First, Middle, Meiden Sumeme) Elizabeth John Koppleman Hartman 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 248 12th Street Pasadena, Maryland 21122

20b. Place of Disposition (Name of cemetery, cremetory or other place)

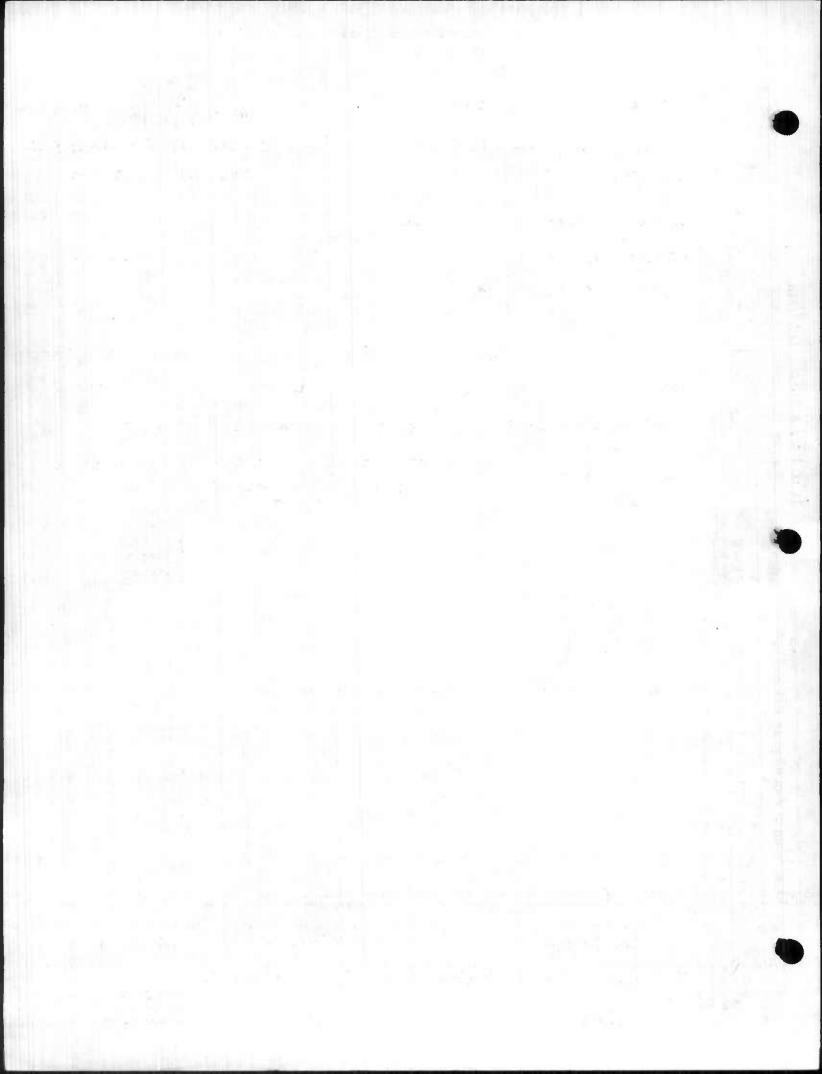
Dete 20c. Location - City or Ton Charlotte Leach (Daughter) 20e. Method of Disposition 20c. Location - City or Town, Steta 1 ☐ Burial 2 M Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Greenmount Crematory 1/27/00 | Baltimore, Maryland 21. Signeture of Funeral Service Licenses 22. Neme and Address of Facility McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 21122 23e. Pert1 Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Deeth Physician Complete heart block
Due to (or es e consequence of):
whe Myscardial what chin /Medicai fmmediete Ceuse (Finel disease or condition resulting in death) Examiner Examiner or Attending Physician: The law requires that the death certificate be executed the burial-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest P.O. Box 68760. ed by the attending physician deteched for use as the buria Physician/Medical Due to (or es e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? been signed by 1 Yes 2 No 3 Probably 4 Unknown Jaclure Division of Vital Records, þ Completed 24b. Ware autopsy findings evailable prior to completion of ceuse of deeth? 24e. Wes en eutopsy performed? certificate hes 1 Yes 2 No 1 ☐ Yes 2 ☑ No Be 25. Wes case referred to medical 28. Plece of Deeth (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 1 ☑ Impatient 2 ☐ ER/Outpetient 3 ☐ DOA After this 27. Manner of Deeth Dete of Injury (Month, Dey Year) Certification: 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred 5 Pending investigation 1 Netural To the Hospital or Attendir within 24 hours efter death.
To the Funeral Director: At completely filled in by the fu death. 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete and plece, end due to the cause(s) and manner as steted.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. Medicai (Check only 29b. Signeture and title of certifies. 29c. License number 29d. Date signed (Month, Dey, Year) 1/24/00 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) 203 Hospital Drive Bosh D 286

Registrar
DHMH 16 Rev 6/95

JAN 2 8 2000

32. Registrer's Signeture

31. Dete filed (Month, Dey, Yeer)



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienen Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year 14, 2000 4c. County of Death 4a Facility Name (If not institution, give street and number) 10:15am Januar 4b. City, Town, or Location of Death Soltimore If Under 24 Hrs. 8 City Medical Center 1 Ye Hopkins Bayview John Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Months Hours 1□M 28 F Yrs. 09/25/1920 292-30-4877 79 Usual Residence of Deceden 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Mahoning Canfield 1 ☐ Yes 2 ☐ No OH 10e Street and Number 10f Zip Code 10g. Citizen of What Country? 3775 Mercedes Place #3 44406 П A 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2 Married White 1 Yes 2 No Specify: Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Florist 12 Horticulturist 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Steve Kolesar Mary Fiffick 19a. Intormant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gayle Dietrich- daughter 1450 Fountain Glen Drive Bel Air MD 21015 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Calvary Cemetery 01/17 Youngstown, Ohio 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Sendos Licenses 22. Name and Address of Fecility Sterling-Ashton-Schwab Funeral Home, Inc 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, Approx. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Breast years Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequence of): Due to (or as a consequence of): Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Reactions [Zosyn+TAXNTERO] 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 2 NO 1 Yes 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) exeminer? 1 Yes 2 No 1 DInpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) Mariner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Netural 5 Pending 1 Yes 2 No Accident investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide

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The law requires that the death certificete be axecuted

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Division of Vital or Attending Physician:

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24 hours after deal Funeral Director:

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Hospital

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Physician

/Medical

Examiner

Director

Funeral

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Completed

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Funeral

Director

Ahow

th end Mental Hygiene. ? Is marked other then "natural", or flams 23s or 28s-1 show traumstic avant, the Medical Examinar must be notified at

Pages 1 and 2 should be filed within 72 hours after neart of Health and Mental Hygione. nts if Itam 27 is marked other than "natural", or its iry or other traumate avant, pre Medical Esseries

permit. Page Department of Important: If any injury or once.

Physician

/Medical

Examiner

Baltimore, Maryland 21215-0020

with the Maryland

death

burial-transit physician s the burial Physician/Medical Completed by page 2 certificata director. Be Medical Certification: To this funeral Affer

25. Was case referred to medical

29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

suran

29c. License number

BALTIMORE

29d. Date signed (Month, Day, Year) January 14, 2000

30. Name and address of person who completed cause of deem (ttem 23a) (Type, Print) JARVAS UMPRA 4940 PATIENT

2000

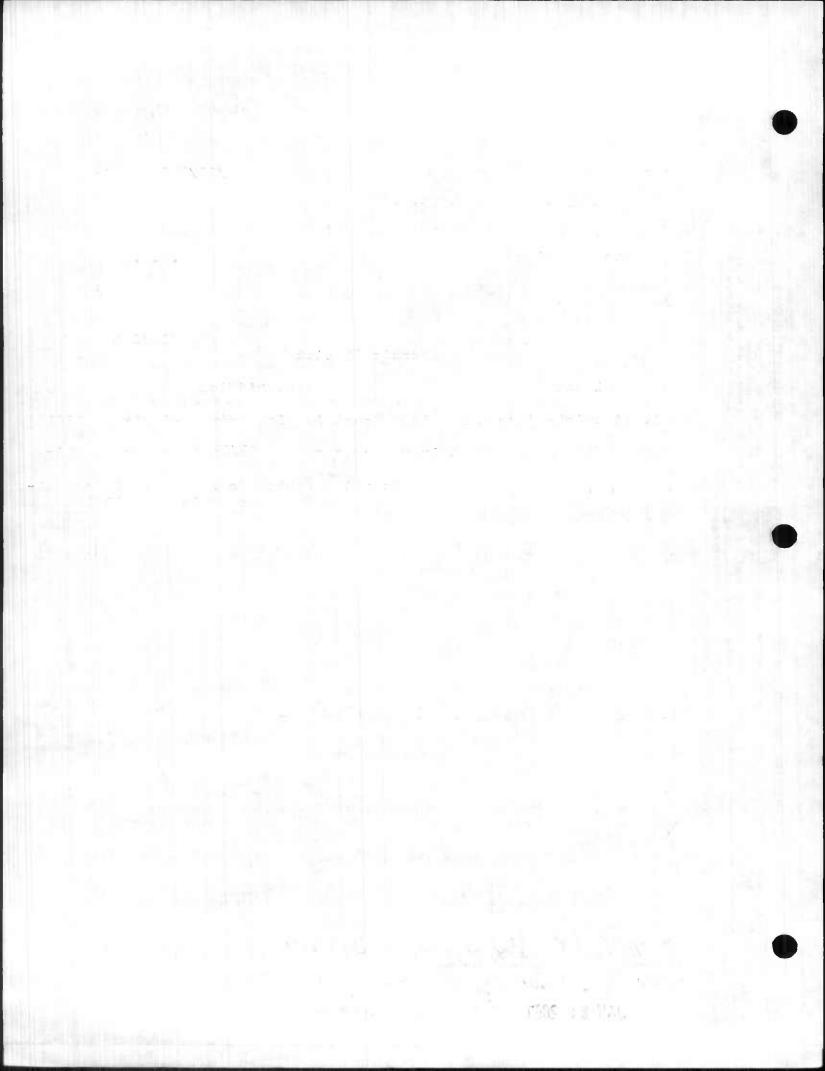
31. Date filed (Month, Day, Year) **JAN 28**

29b. Signature and title of certifier

32. Registrar's Signature JENN

State Registrar

DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month **Physician** 0 20794 rupk 24- 2000 City, Town, or Location of Death / AM /Medical 4s Facility Name (If not institution, give street and number) 4c. County of Deeth Examiner MEDICAL BAUTIMORE AN AUSTOWN
If Under 24 Hrs. 8. Date of Bit 6. Sex 100 M 2□ F 8. Date of Birth (Month, Day. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** Months Min Days Hours 046-09-568 Director the Menyland 10a. Stata 10b. County 10c. City, Town or Location Nema 23a or 28a-f ahow 10d. Inside City Limits 1 Yea 2□No HAver WALLINGFOLD Director NS 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Nema 23a or 2 shorly injury or other traumatic avent, the Medical Examination and page. LANE MARY ANN S.A Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 00 No If Yes, Give Year or Dates: Wea Decedent of Hispanic Origin? (Specify Yas or No If Yes, apecify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Bleck, White, etc. 1 Never Married 2 Married Baltlmore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Completed by WHITE 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) FULLER FACTOR 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) 8 NWOWN UNKNOWN e/Relationship (Type, 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Watercites SUN 546 blumbia, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State Dete 1 Burial 2 Cremation 3 Removal from State 1/28/2000 EAST Granby 4 Donation 5 DOther (Specify) 21. Signature of Funeral Service Lices 22. Name and Address of Facility WITZHC Funeral Homes, Inc 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel disease or condition resulting in death) INtaritio Due to (or as e consequence of): Examiner Physician/Medical Examiner The lew requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) physician s the burlai Division of Vital Records, P.O. Box 68760. ed events n death) Last Due to (or as a consequence of) resulting in de signed by the attendin d be detached for use Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 Probably 4 Unknown Completed by 24b. Wera autopsy findings available prior to completion of cause of death? 24a. Was en autopsy performed? page 2 should 2 PNo 1 ☐ Yes 2 ☐ No 1 Yes or Attending Physician: 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral 28a. Date of Injury (Month, Day Year) 27 Manner of Death 28c. Injury at Work? 28d. Describe how Injury occurred 5 Pending investigation 1 Natural 24 hours ettar deeth, Funerel Director: Al 2 Accident 1 Yes 2 No 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Stele) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) completely filled in by 4 ☐ Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the 29a. Certifier ner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 \$ 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1/05 th 1/45 7 32. Registrar's Signeture 10spital

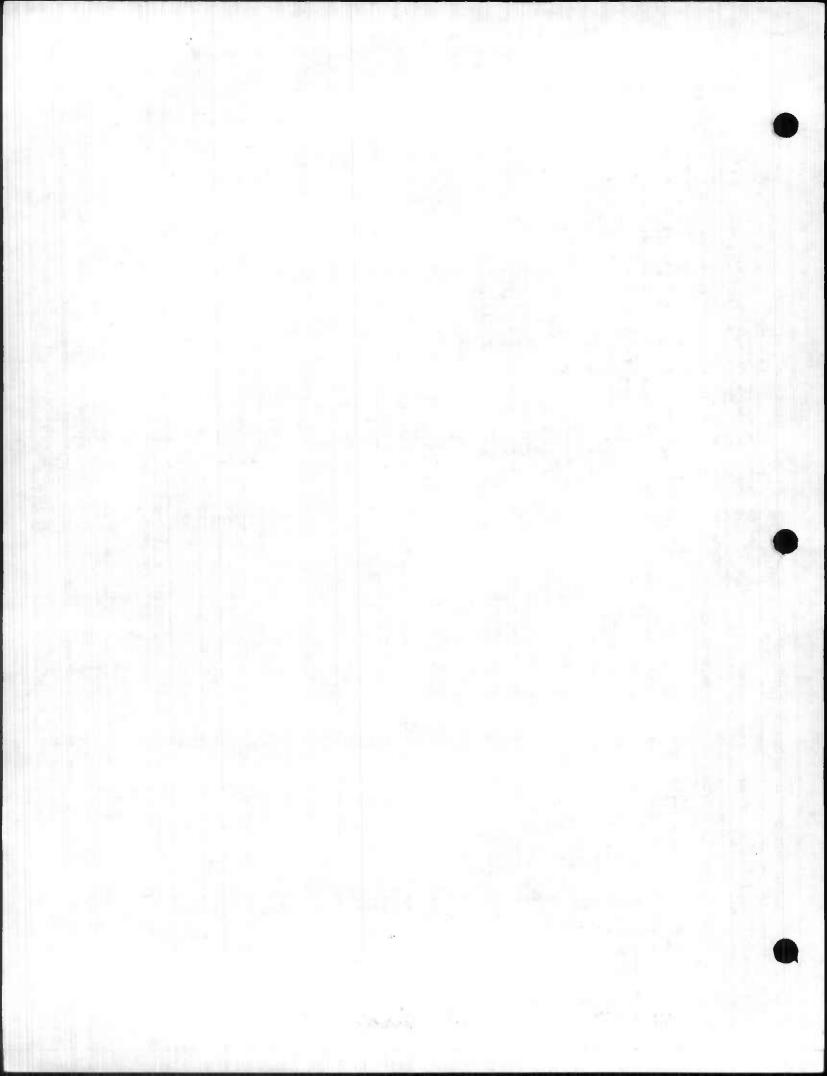
DHMH 16 Rev 6/95

State

Registrar

31. Date filed (Morith, Day,

JAN 28 2000



Please Type or Print in Black Indelibie ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death / Month **Physician** KING 0814 4b. City, Town, or Location of Death USTINA 25, 2000 /Medical 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner -ALLSTON GENERAL HOSPITAL Fallston Harford If Under 24 Hrs. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (Stata or Foreign Country) **Funeral** Days 1□M 2XF Months Hours 217-01-1246 7-05-1920 Director MD Usual Residence of Decedent 10a. Stata 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene.
Important: If Item 27 is marked other than "natural", or items 23s or 28s-f ahow any fujury or other traumatic avant, the Mades Example must be notified at page. 10c. City, Town or Location 10d. Inside City Limits MD **Baltimore** Rosedale 1 ☐ Yas 2 No Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 5702 Hamilton Ave. 21237 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 11 Marital Status 14. Race - American Indian. Black, Whita, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: by 3 ☐ Widowed 4 ☐ Divorced white Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home 8 Homemaker 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Joseph F. Mol1 Judith Wagner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Linda Kovac / daughter 2425 Dixie Lane, Forest Hill, MD 21050 20b. Place of Disposition (Name of cometery, crematory or other place)
Gardens of Faith 20a. Method of Disposition 20c. Location - City or Town, Stata 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 1 - 29 - 00Baltimore, MD 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licenses 22. Nama and Address of Facility 1211 Crach/Rosedale Funeral Home 1211 Chesaco Ave. Rosedale, MD 21237 23a. Part1. Enter the disease, or complications that cause (the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final Luceks diseasa or condition rasulting in death) Examiner Physician/Medical Examiner ears Ten attending physician and for use as the burist-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a conse Box 68760. hend Ozonan discase Dua to (o) as a consequence of) Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Ware autopsy findings available prior to 24a. Was an autopsy performed? completion of causa of death? 1 ☐ Yes 2 ☐ No

 Hospital or Attanding Physician: The law requires that the death certificate be associated to be broated black of death.
 Funeral Director: After this certificate has been signed by the attending physician and leasy filled in by the funeral director, page 2 should be deteched for use as the burish-transit Division of Vital

ustina KING

Completed 8 Medical Certification: To

25. Was casa referred to medical axaminer? 1□ Yes 2 No

27. Manner of Death 1 Natural
2 Accident 5 Pending investigation 6 ☐ Could not be 3 ☐ Suicide 4 Homicide

2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Day Year)

28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify)

28b. Time of

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work?

26. Place of Death (Check only one)

28d. Describe how injury occurred

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.

28f. Location (Street and Number or Rural Routa Number, City or Town, State)

(Check only one)

29a. Certifier

aller S. C. Sun, m.D

29c. License number D-18779

1 Yes 2 No

29d Data signed (Month, Day, Year) January 26, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1716 Harford Rd. Ste. 105 Fallston MD ALBERT S. C. SUN, M.D.

31. Date filed (Month, Day, Year)

JAN 28 2000

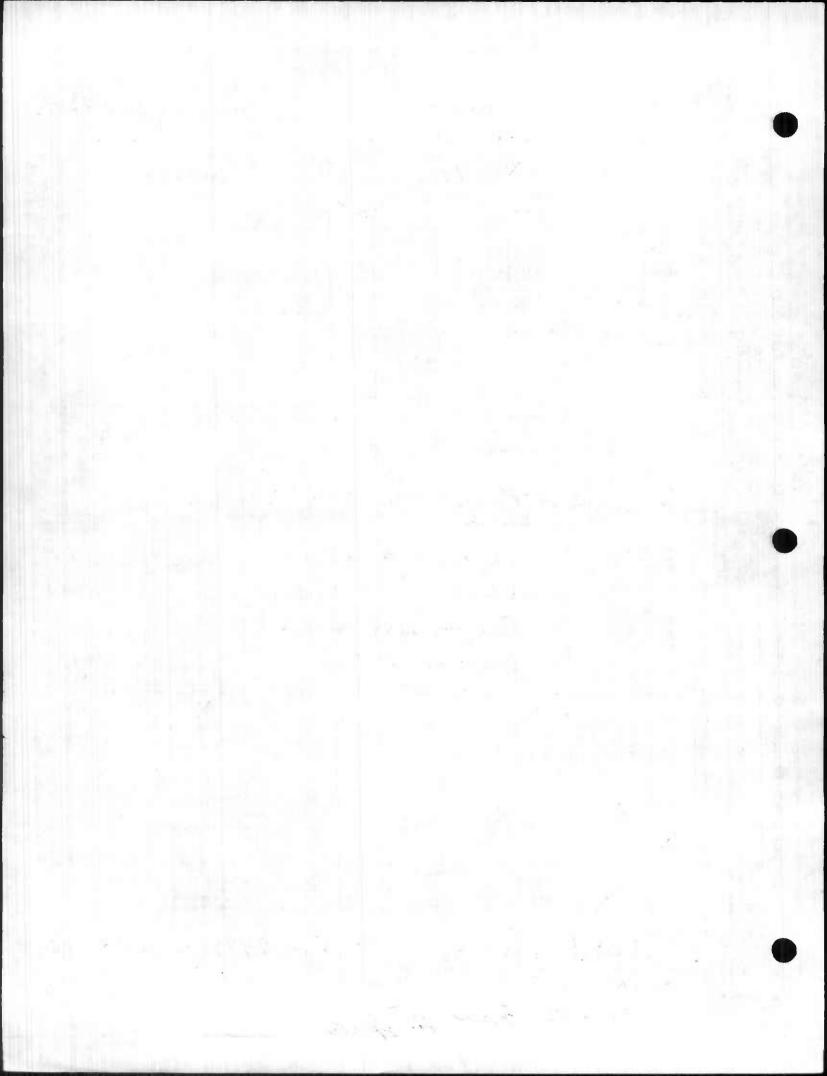
32 Registrar's Signatura

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State Registrar

DHMH 16 Ray 6/95

To the Hosp within 24 hor To the Fune completely fi



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year Margaret A. Laubach 02:55 Am 25 2000 Jan 4a Facility Name If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death of Maryland 7. Age (In yrs. last birthday) If Under 1 Year Baltimore If Under 24 Hrs. 8. Da University 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 1□M 2万F Months Maryland Days Hours 220-14-2427 10,1924 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No Maryland Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1667 Thetford Road 21286 U.S.A. 14. Race - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2√ No Specify 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Secretary Balto. County Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Conrad Kratz Marie Berger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) Mr. Jeffrey R. Laubach/Son Cockeysville, Md. 21030 11 Clarion Court 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith Cemetery 1/29/2000 Overlea, Maryland 21. Signature of Funeral Service Licens 22. Name and Address of Facility 1050 York Road Ruck Towson Funeral Home, Inc. Towson, Md. 21204 CER plications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one caused in each line. 23a. Part1. Enter the disease, or complication shock, or heart failure. List only one care Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) piratory THE RY MEDICAL PER Due to (or as a consequence of): Contr ulmonary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Colli Vehicle Sion Motor Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yan 2 No 3 Probably 4 Unknown Pancreutic Cancer 24b. Were autopsy findings available prior to completion of causa of death? 24a. Was an autopsy performed? 2 No 1 Yas 20 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 Yes 2□ No 1 M Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28d. Describe how injury occurred Subject driver of Car Struck another Car 281. Location (Street and Number or Rural Route Number, Cay of Town, State) In parkville Mo 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Tima of Injury 28c. Injury at Work? 1 Natural 5 Pending Jan 12, 2000 1 Yes 2 No 9:44 anm 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 Homicide Street 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the 29a. Certifier

Examiner sician and burlei-transit The lew requires that the death certificate be assecuted physician s the burle Box 68760. Physician/Medical U80 08 P.O. ata has been signed page 2 should be del Division of Vital Records. P Completed certificate has or Attending Physician: funeral director, 8 Certification: To this After within 24 hours after deeth. To the Funeral Director: A filled in by Medical completely

Physician

/Medical

Examiner

Director

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the Maryland

Pages 1 and 2 should be filed within 72 hours etter deeth within and Mental Hygiena.
Intelf Mem 27 Is marked other than "netural; or items 23s or usy or other than the Member that way or other thatmatch sevent, the Med

pemit. Pages Department of Important: If it eny injury or o

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Baitimore, Maryland

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State Registrar

IAN 28 2000

30. Name and address of person who con

(Check only

29b. Signature and title of contiller

Univesta 31. Date filed (Month, Day)

gistrer's Signature 39:

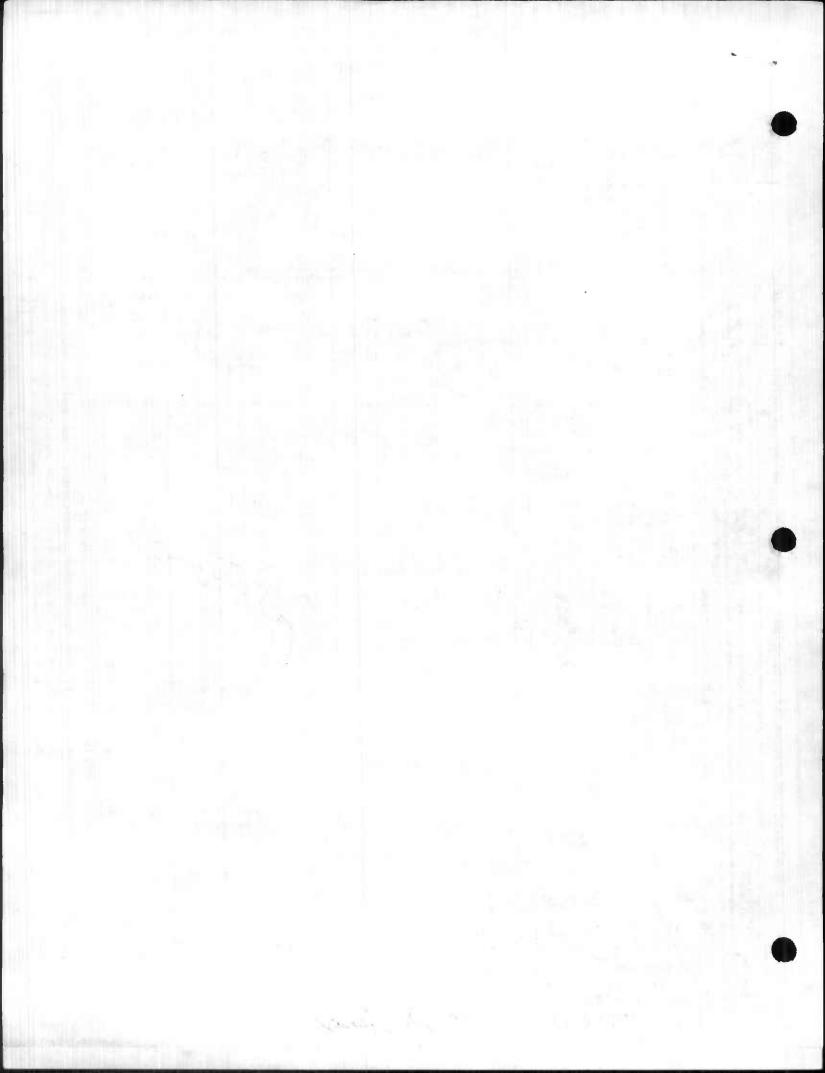
e of death (Item 23a) (Type, Print)

ner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

Jan

29c. License number



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Month Day Year

1, Decedent's Name (First, Middle, Last) 3. Time of Death Physician Estelle С. 21, 2000 January 7:30 A.M. /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** North Mariner Health & Rehabilitation of Arunde1 Glen Burnie If Under 24 Hrs. 8. Dete Anne Arundel 7. Age (In yrs. last birthday) | | Under | | Months | 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min. 10 M 2 DF Days Hours Feb. 220-07-5931 1902 Director 10, Virginia Usual Residence of Deceden the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at 1 Yes 2 No Director Md. Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1030 First Street Nems 23a 21060 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 0 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-iff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Stalus adical Examiner Black, White, etc. of 2 should be filed within 72 hours after the and Mental Hygiene.
It is marked other than "natural", or lies traumatic event, the Medical Examines. 1 Never Married 2 Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: þ 3 ₩idowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 6th Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) permit. Pages 1 and 2 should be file Department of Neath and Mental Hy Important: If Ilsm 27 is marked oth any Injury or other traumatic event Be Joseph Harrison Lelia Pitts 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Clifford Lewis (Son 1028 Rockhill Avenue Baltimore, Maryland 21229 20b. Place of Disposition (Name of cemetery, cremetery or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 DBurial 2 Cremation 3 Removal from State Glen Haven Memorial Park 1/25/00 Glen Burnie, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 27. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. Kevin E. Ecker 237 E. Patapsco Avenue Baltimore, Maryland 21225 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical weeks Examiner Examine Demen sician and buriel-transit The law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) physician s the buriel Box 68760, Physician/Medical Due to (or as a consequence of): 80 signed by the attending to be detached for use as P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? brillation 1 Yaa 2 No 3 Probably 4X Unknown Division of Vital Records. þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed has certificate 1 Yes 20 No 1 ☐ Yes 2 No or Attending Physicien: 25. Was case referred to medical axaminer? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After 1 Sivatural
2 Accident 5 Pending investigation 24 hours after death. 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated Medical 29a. Certifier completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the Within 2 29b. Signature againtile of certifier 29c. License number 29d. Date signed (Month, Day, Year) 50470 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore MD &1227 4000 Annapolis TLURI

State
Registrar

DHMH 16 Ray 6/95

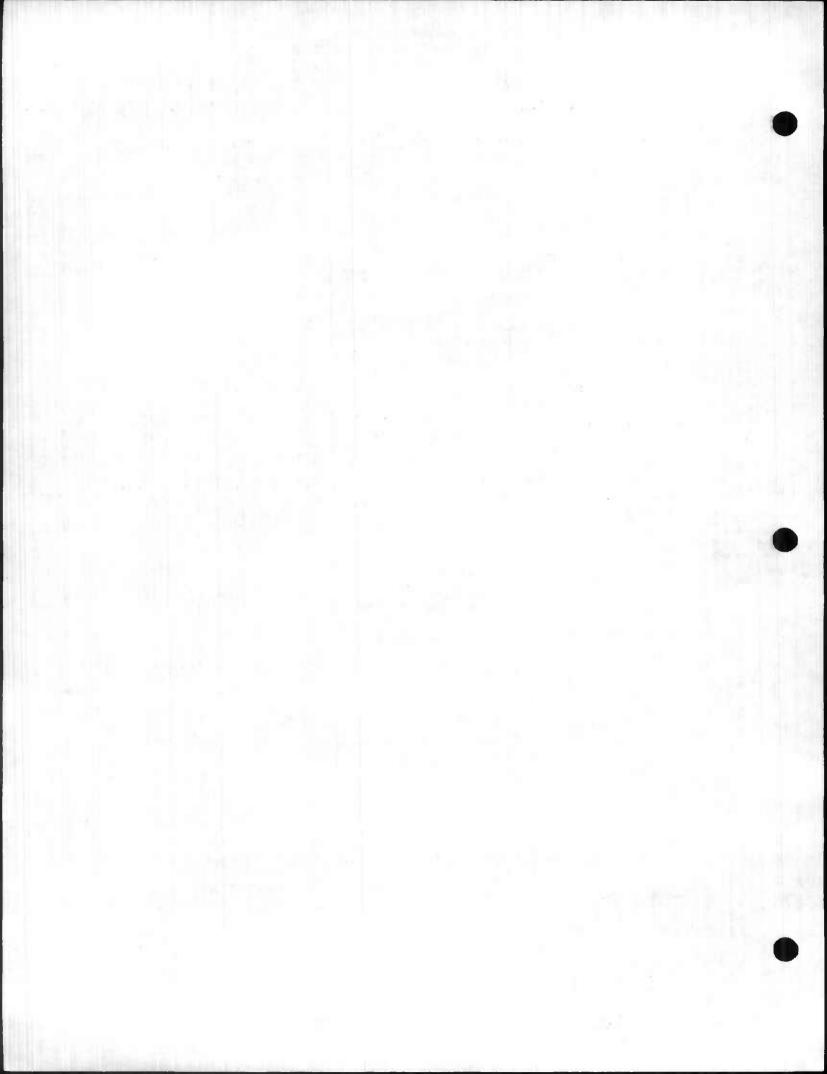
JAN 2 8 2000

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Server & Apr

5 Sporks



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Des **Physician** Lerch Anna JAN. 25, 2000 9:30PM /Medical 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Crofton Convalescent Center Crofton Anne Arundel If Under 24 Hrs. 5 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Ye 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ☐ M 2 🖫 F 214-50-8046 87 2, Director Nov. 1912 Maryland Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1□ Yes 2√No Director 288-1 Anne Arundel Lothian 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? b 5407 Solomons Island Road 20711 Itsms 23a IISA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, 11. Merital Status Black, White, etc. filed within 72 hours after I ☐ Yes 2 ☑ No 1 Never Married 2 Married Baltimore, Maryland 21215-0020 8 1 ☐ Yes 2 ☑ No Specify: Specify: White à 3K Widowed 4 Divorced "natural", Yeer or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiens. College (1-4or 5+) Etementary/Secondary (0-12) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be nent of Health and Mental John Gerstner 2 Barbara Scheussler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) J.J. Bernard Lerch III (son) 5407 Solomons Island Road, Lothian, MD 20711 Important: If Item 27 any injury or other tr 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 01/28/ 2000 20a. Method of Disposition 20c. Location - City or Town, Stata Burlai 2 Cremation 3 Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Lakemont Memorial Gardens Davidsonville, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401 0 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Ceuse (Final years disease or condition resulting in death) Examiner Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last and Due to (or es a consequence of): physicien s the buriel Box 68760, Physician/Medical Due to (or es e consequence of): 88 been signed by the a should be deteched t P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown Division of Vital Records. þ 24b. Were autopsy findings svailable prior to completion of cause of death? Completed 24a. Was an autopsy performed? page 2 2 No certificate 1 Yes 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: funeral director, Be 25. Was case referred to medical axaminer? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) edical Certification: To 1 Yes 258 No 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Menner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of tnjury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide CEC Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one) \$ 29b. Signature and title-of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROFTON

DHMH 16 Rev 6/95

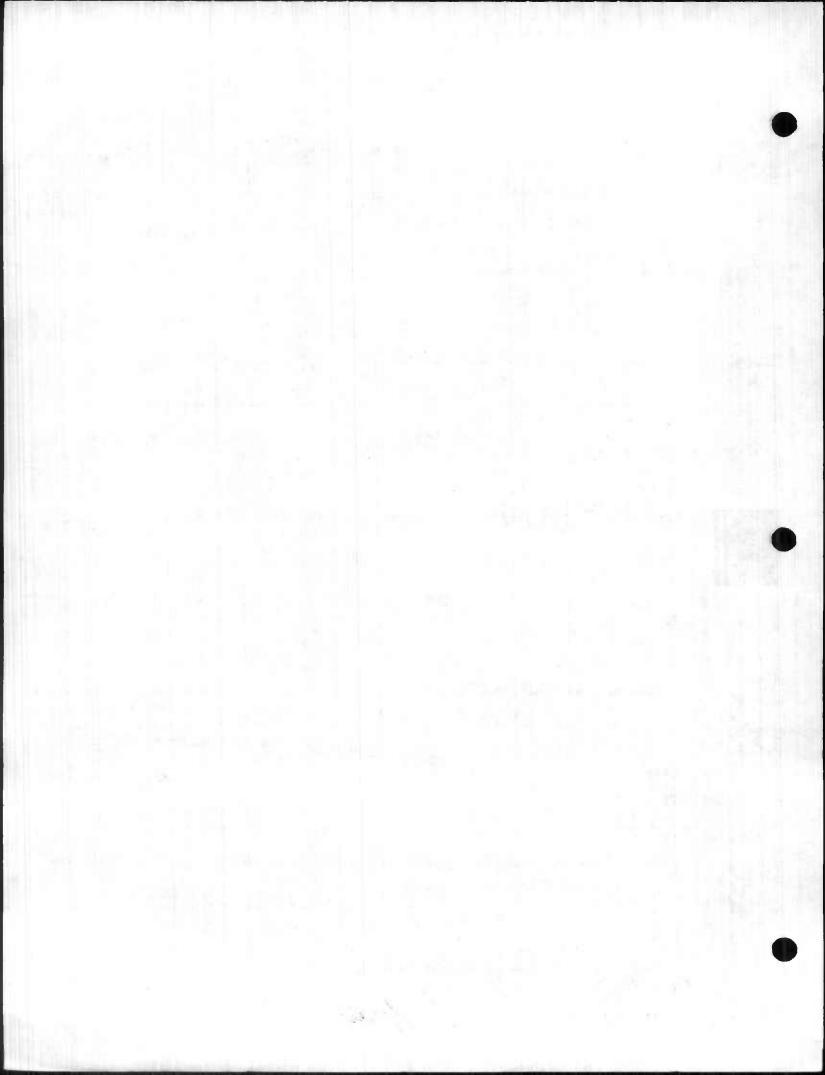
State

Registrar

31. Date filed (Month, Day, Year)

JAN 28 2000

32. Registrar's Signeture



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Deeth Month Year **Physician** Geoffrey J. Leighton 23 January 2000 1:30 am /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2315 Westport Lane Crofton Anne Arundel If Under 24 Hrs. Hours Min. If Under 1 Yeer 5. Sociel Security Number 7. Age (In vrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplace (Stete or Foreign Country) **Funeral** Deys 10XM 2□ F Months 148-34-5523 82 Director July 16,1917 England Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show must be notified 1 ☐ Yes 2 No Funeral Director Anne Arundel Crofton 200 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Herra 23a or 2315 Westport Lane 21114 USA 13. Was Decedent of Hispenic Origin? (Specify Yes or No-lt Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, 12. Wes Decedent Ever in U,S. Armed Forces? Bleck, White, etc. Pages 1 and 2 should be liked within 72 hours alter near of Health and Mental Hydjene.
Att if item 27 is marked other than "natural, or its uny or other trauming event, the Medical Examines by or other trauming event, the Medical Examines Yes 2 No 1 ☐ Never Merried 2 Merried 21215-0020 1 Yes XXNo Specify: White Specify: þ 3 Widowed 4 Divorced Yeer or Detes: Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 12 Electronics Engineer Electronics Maryland 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be James Leighton Laura Lucas 19a. Intormant's Neme/Reletionship (Type, Print) 19b. Melling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty H. Leighton (Wife) 2315 Westport Lane, Crofton, MD 21114 altimore, 20e. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete Dete 1 ☐ Buriel 2 Ø Cremetion 3 ☐ Removel trom State 01/24/ Department of Important: If any injury or 2005 Metro Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2000 Baltimore, MD 21. Signa 22. Neme and Address ot Fecility Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401 23e. Part1. Enter the disease, or emplications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart teilure. List only one cause on each line. Approximate Intervel Between Onset and Deeth **Physician** /Medical tmmediete Cause (Finel irrhosis 1 years diseese or condition resulting in death) Examiner Physician/Medical Examiner Attending Physician: The law requires that the death certificate be assecuted pur Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or es e consequence of): Box 68760, signed by the attending physician to be detached for use as the buria Due to (or es a consequence ot) Pert tt. Other stgnificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. P.O. 23b. Did tobacco use contribute to the cause of death? Insulin Dependant Drubetes Mellitys 1 Yes 2 No 3 Probably 4 Unknown Records, Completed by 24a. Wes an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No this certificate 1 ☐ Yes 2 ☐ No Division of Vital funeral director, Be 25. Was case reterred to medice! 26. Place of Deeth (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After 5 Pending Investigation 1 Neturel
2 Accident ne Hospital or Attendit n 24 hours after death. Ne Funeral Director: Alpietely filled in by the fu death. 1 ☐ Yes 2 ☐ No 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Plece of Injury - At home, term, street, tectory, office building, etc. (Specify) 4 Homicide 29e. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, end due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and menner stated. Medical To the Hosp within 24 hor To the Fune completely fi 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) adjet ml) 00033296 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Neil E Pudgett mo 7711 Quarterfield RO Gien Burrie MD 21061 31. Dete tiled (Month, Day, Year)

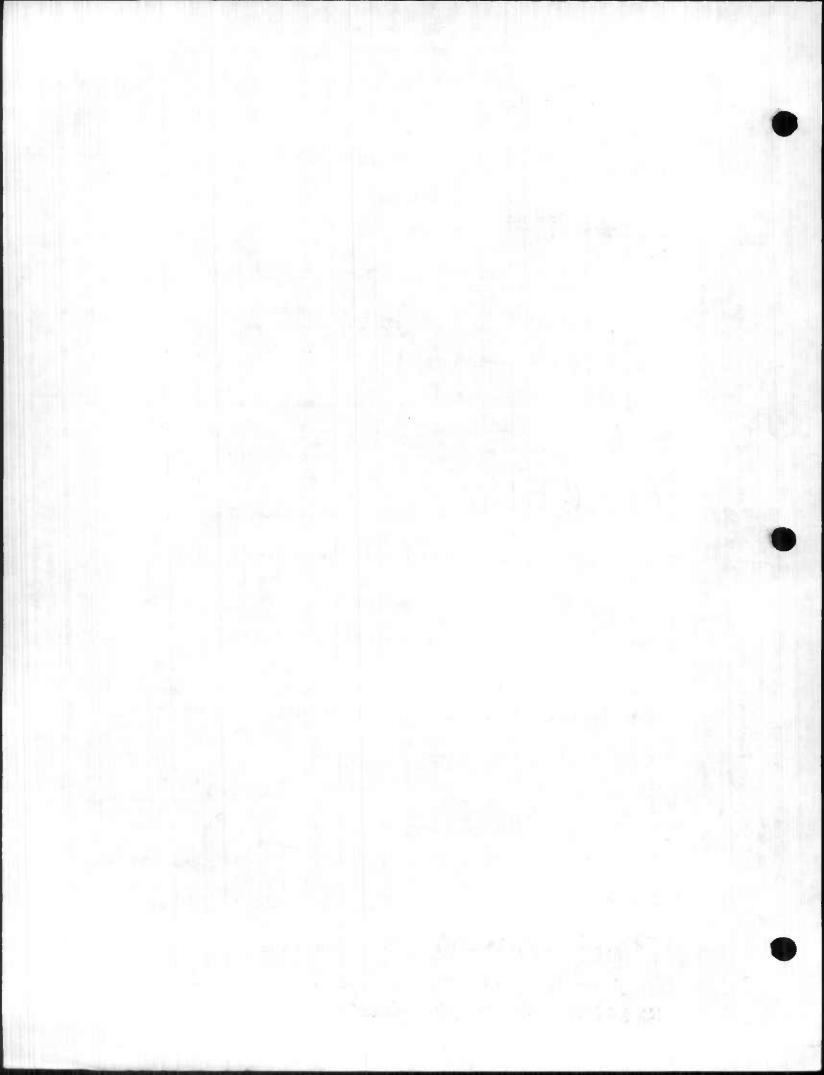
DHMH 16 Ray 6/95

State

Registrar

JAN 28 2000

32. Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Name (First, Middla, Last) 2. Data of Death 3. Time of Death LYNCH Month JEANETTE FVELTN JANUART 2000 24 4a. Facility Neme (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death (TOO) HUSPITAL BALTIMURE SAMARITAN BALTIMORE if Undar 24 Hrs. 8. Deta of Birth
Hours Min. July 11 If Undar 1 Year 5. Sociei Security Number 7. Age (In yrs. last birthday) 9. Birthpiace (Stete or Foreign Days 1 M 2 F 86 215-84-4100 Yrs Mary Tand Usual Rasidance of Decedant 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 ☐ Yas 2 € No Maryland Baltimore Parkville 10e. Street end Number 10f. Zip Code 10g. Citizan of What Country? 7700 Oakleigh Road 21234 United States 12. Was Dacedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Datas: Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, etc.) 14. Raca - Amarican Indien, Black, White, atc. 1 ☐ Nevar Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: White 3 X Widowed 4 □ Divorced 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elamentary/Secondery (0-12) Collega (1-4or 5+) Homemaker Own Home 17. Fathar's Name (First, Middla, Last) 18. Mother's Neme (First, Middle, Maldan Sumema) Martin Debelius Caroline Hanna 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Coda) Carol Lynn Hilditch / Niece 5104 Hazelwood Avenue Baltimore, MD 21206 20b. Placa of Disposition (Neme of cemetery, crematory or other placa) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 K Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Specify) Moreland Memorial Park 1/29/2000 Parkville, Maryland 21. Signatura of Funetal Sarvice Licensee Timothy Harman 22. Nama and Addrass of Facility Leonard J. Ruck, Inc. Funeral Home 5305 Harford Road Baltimore, MD 21214 23a. Part1. Enter the insease, or complications that ceused the daeth. Do not anter the mode of dying, such as cardiac or respiretory arrast, shock, or haer initiura. List only ona causa on aach lina. Approximate Intervel Betw Onsat and Death Immedieta Causa (Final disaasa or condition rasulting In daath) Sequentielly list conditions, if any, laading to Immadiata ceuse. Entar Underlying Causa (Disease or injury that initiated evants rasulting in daath) Last Dua to (or as a consequence of) Dua to (or as a consequanca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Little Rnown 24a. Was an autopsy periomad? 24b. Wara autopsy findings aveilabla prior to completion of ceuse of daath? 1 Yas 2 No 1 ☐ Yes 2 ☐ No 25. Was cese rafarred to madical axaminar? 26. Place of Death (Check only ona) Other: 4 Nursing Home 5 Rasidence 6 Other (Specify) 1 Yes 2 No 1 Dinpatiant 2 ER/Outpatient 3 DOA 27. Manner of Daath 28a. Deta of Injury (Month, Day Year) 28b. Tima of 28c. Injury et Work? 28d. Dascribe how injury occurred 5 Panding invastigation 1 Netural

Physiclan /Medical Examiner

Physician

/Medical

Examiner

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.. Pages 1 and 2 should be file timent of Health end Mental Hi tant: If Itam 27 is marked oth jury or other traumatic even

permit. Pages Department of Important: If it any injury or o

Baltimore, Maryland 21215-0020

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Box 68760,

P.0.

Records,

of Vital

Division

or Attending Physician:

Hospital

sician and bunal-transit physician s the burial Physician/Medical ate has been signed by the a page 2 should be datached þ Completed certificate director, Be 10 this in by the funeral After s after deeth.

Certification: To the Hospital within 24 hours a To the Funeral Completely filled

Examiner

State Registrar

Medical

29b. Signatura and titla of certifiar

6 Could not be determined

2 Accidant 3 Suicida

4 Homicide

29a. Certifiar

and mannar stated.

2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, dete end place, and due to the ceuse(s)

1 🗹 Certifying Physician: To the best of my knowledge, deeth occurred et tha tima, date and place, and dua to tha ceusa(s) and mannar as stated.

1 ☐ Yas 2 ☐ No

29d. Date signed (Month, Dey, Year) IMMARY

28f. Location (Streat and Number or Rural Routa Number, City or Town, Stete)

30. Nama and eddrass of person who completed ceusa of death (Item 23e) (Type, Print) SAMARITAN HUSPITAL AIGBEDION

G00 1

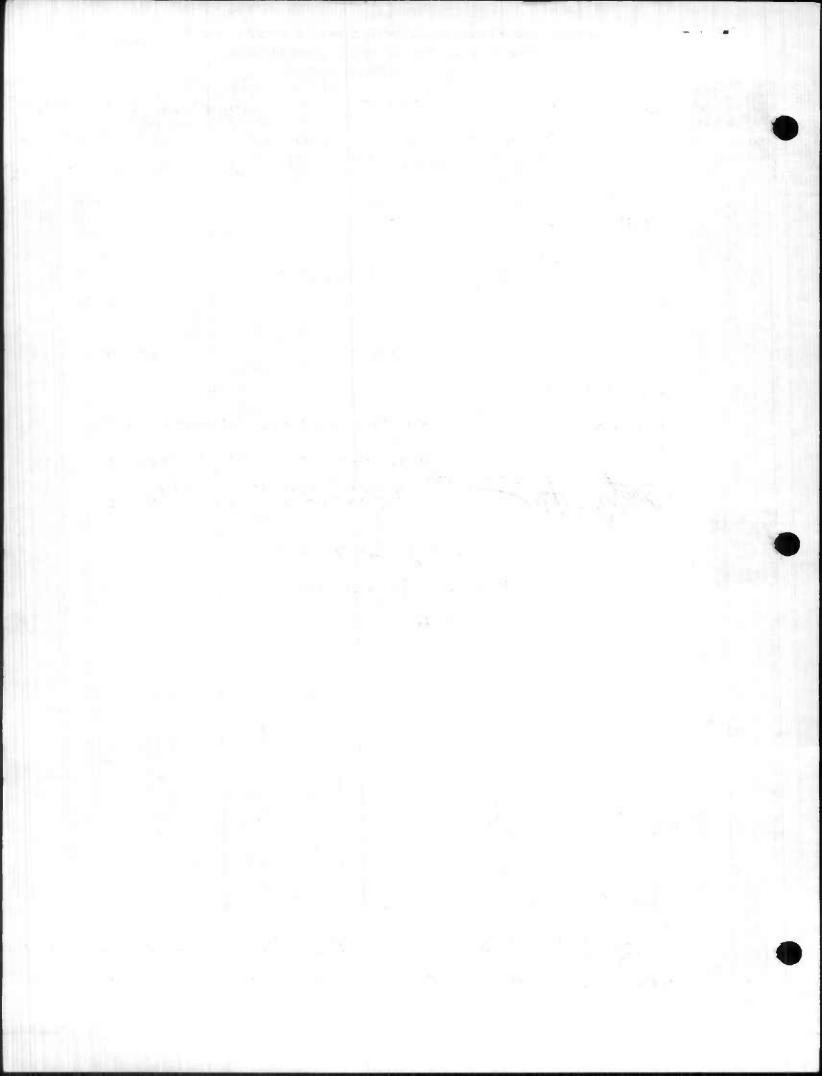
28a. Place of Injury - At home, farm, straat, factory, office building, etc. (Spacify)

31. Dete filed (Mapth.) 2 8 2000

32. Registrar's Signatura

& Sparts

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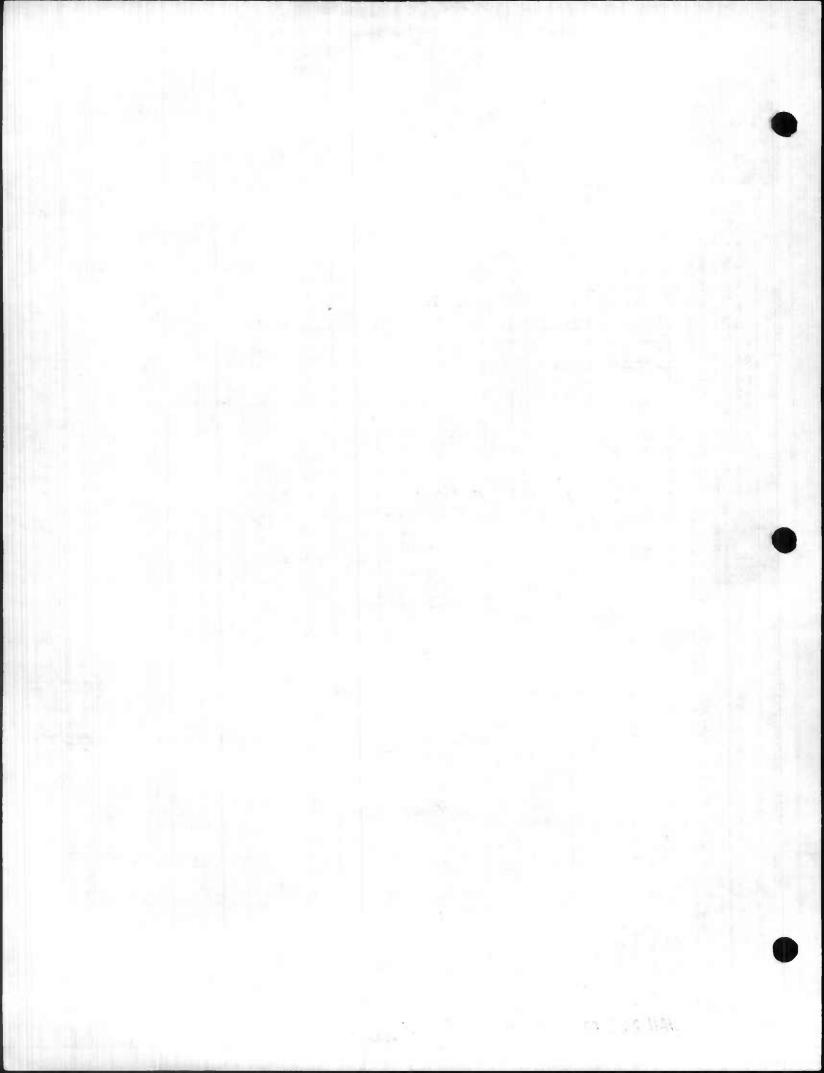
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

| sician | | Decedent's Name (First, Middle, Last) WILLIAM A LUTTRELL | | | | | | | 2. Date of D Month Jan | Death Day 26 | Year 2000 | 3. Tima of Death 12:40P | | | | | | |
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| edical miner | | Facility Name (| | | | | | | - | 4b. City, Town, or I | | | | | | | | |
| neral | | HOWARD | | | | | | | | COLUMBIA | 1 | HOWARD | | | | | | |
| | 5. 5 | Social Security N | Number | 6. Sex | M 2 F | 7. Age (In | yrs. last birth | Months | 1 Year Days | If Under 24 Hrs. Hours Min. | 8. Date of B | irth Day, Year) | 9. Birth | place (State or Foreig | | | | |
| tor | 110 | 218-22 | | 1 | M 2U F | | 73 ^Y | rs. | | 1 1511 | | ry 9, 1927 | | Maryland | | | | |
| | 1 | uel Residance o a. Stata | 10b. County | , | | 100 | c. City, Town | or Location | | | | | | 10d. Inside City Limits | | | | |
| ō | | Mandand | | Har | | | | | | - 11 O'1 | | | 1 □ Yes | | | | | |
| Directo | 10 | Maryland e. Street and Nu | mber | Howard | | | | 10f. Zip | Ellicott City | | 10g. Citizen of What Country? | | ntry? | | | | | |
| Examiner must by Funeral | | 3008 Autum Branch Lane, Apt. A | | | | | | 21043 | | | | | u.s | S.A. | | | | |
| | 11. | | | | 2. Was Decedent Ever in U,S. Armed Forces? 1. Of Yes 2 □ No HY9s, Give Year or Datas: WWIII | | | 13. Was Deced | Vas Decedent of Hispanic Origin? (Sp Yes, specify Cuban, Mexican, Puerto | | | No- 14. | 14. Race - American Indian, | | | | | |
| | 1 | | | | | | | | | | | | Black, Whita, atc. Specify: White | | | | | |
| The second second | | /Sne | 15. Deceden | | icetion 16a. | | | Decedent's Usual Occupetion (Give kind of work done during most of worki | | | 16b. Kind o | | of Business/Industry | | | | | |
| | - | Elementary/Seco | | 31 91400 | College (1-4or 5+) | | life. DO NOT use retired) | | | N g | | Engineering | | | | | | |
| | 17 | Fathada Nama | (Fina saidale | 1 4) | 3 | 3 | | | Mechanical Engineer 18. Mother's Name (First, Midd | | | | | | | | | |
| 2 | | Father's Name | | | | | | | | 18. Mothers Nar | | | | | | | | |
| | | a. Informant's N | | | ice Lutt | rell | 10h | Mailing Address | (Street | and Number or Ru | - | follie Wot | | n Codel | | | | |
| | 13 | | | | | | 190. | | | | | | | | | | | |
| | 208 | a. Method of Dis | | | | | 0b. Place of I | Disposition (Nar | me of | Branch Lane | Date | | on - City or To | | | | | |
| | | 1 Burial 2 | Cremation | 3 □Ra | moval from | State | | ntv Cremati | | ervices, Inc. p | 1/29/2000 | | Pulka avilla | Mandand | | | | |
| | 21 | . Signature of Fi | | | | | 7 111 0 0 011 | 22. Name an | | | 1/20/2000 | 1 | sykesville | e, Maryland | | | | |
| | | 1911 | 1000000 | 1 | 1_11 | MO | 1204 | | Slack | Funeral Hor Old Columbi | ne, P.A. | | | | | | | |
| | Im | shock, or hea mediate Cause seese or condition sulting in death) | rt failure. List (Final | complication only one | ations that | each line. | te M | ot enter the mod | de of dyin | Old Columbi | or respiratory | cott City, N arrest, | MD 21043 | Approximete Interval Batween Onset and Deeth | | | | |
| 3010 | Se if a ca ca the | shock, or hea mediate Cause seese or condition | in failure. List | a. | ations that | Due | to (or as a co | yocardial | de of dyin | ng, such as cerdiad | or respiratory | cott City, N | /ID 21043 | Approximete Interval Batween Onset and Deeth | | | | |
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DHMH 16 Rev 6/95

P. Sparks

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DHMH 16 Rev 6/95

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Please Type or Print in Biack Indelibie ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Dev JAMES Mc DANIEL 22;50 .23,2000 JAN 4e Facility Neme (If not institution, giva street end number) 4b. City, Town, or Location of Death 4c. County of Deeth HARFORD MEMORIAL HOSPITAL GRACE HARFORD COUN 8. Date of Birth (Month, Day, Year) JUL. 12, 1958 MARYLAND HARFORD COUNTY HARVE DE If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) Hours Min Days 10 M 2 F Months 213 70 1858 Usual Residence of Decedent 10a. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits t ☐ Yas 2 No MD. HARFORD **EDGEWOOD** 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 3054 EBBTIDE DRIVE 21040 S OF A t4. Race - American Indian, 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 2 No. If Yes, Give Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Bleck, White, etc. 1 Never Merried 2 Married 1 ☐ Yes 2 No Specify: Specify: BLACK 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) YEARS MANAGER SEA FOOD STORE 17. Fathar's Neme (First, Middla, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) BISHOP ELIJAH McDANIEL LAURA CABBAGESTALK 19a. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) NELLIE R. McDANIEL (WIFE) MD. 21040 3054 EBBTIDE DRIVE EDGEWOOD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) Dete 20c. Location - City or Town, Stete Burial 2 Cremation 3 Remove) from Stete BALTIMORE, MD. KING MEMORIAL PARK 1/29/2000 21. Signature of Funeral Service Liceses LFM S Т. GWYNN 22. Name and Address of Facility LEWIS T. GWYNN FUNERAL HOME 21215-6393 23a. Part1. Enter the disease, or complications that sused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feiture. List only one cause on a sch line. . MD. Approximate Interval Between Onset and Deeth Immediate Causa (Final disaese or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ASCVP Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yas 2 No 25. Was case referred to medical axaminer? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 1 ■Inpatient 2 ■ ER/Outpatient 3 ■ DOA 28e. Date of Injury (Month, Dey Year) 27. Menner of Death 28d. Describe how injury occurred 28h Time of 28c. Injury at 5 Pending investigation 1 Netural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Pleca of Injury - At home, term, street, tectory, office building, etc. (Specify) 3 ☐ Suicide 28t. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide 29e. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated. (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner steted.

Mc Daniel, Jones Attending Physician: To the Hospital or Attandi within 24 hours after death. To the Funeral Director: A

Physician

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Examiner

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must be notified at

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permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygien Important: if item 27 is marked other thy any injury or other traumatic avant, trained and train

Physician /Medical

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Physician/Medical Examiner

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Be Completed

Certification: To

Medical

death Hems.

filed within 72 hours after

21215-0020

Baltimore, Maryland

Funeral Director

Completed by

DHMH 16 Rev 6/95

State Registrar 31. Deta filed (Month, Day, Year)

29b. Signature and title of cartifly



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

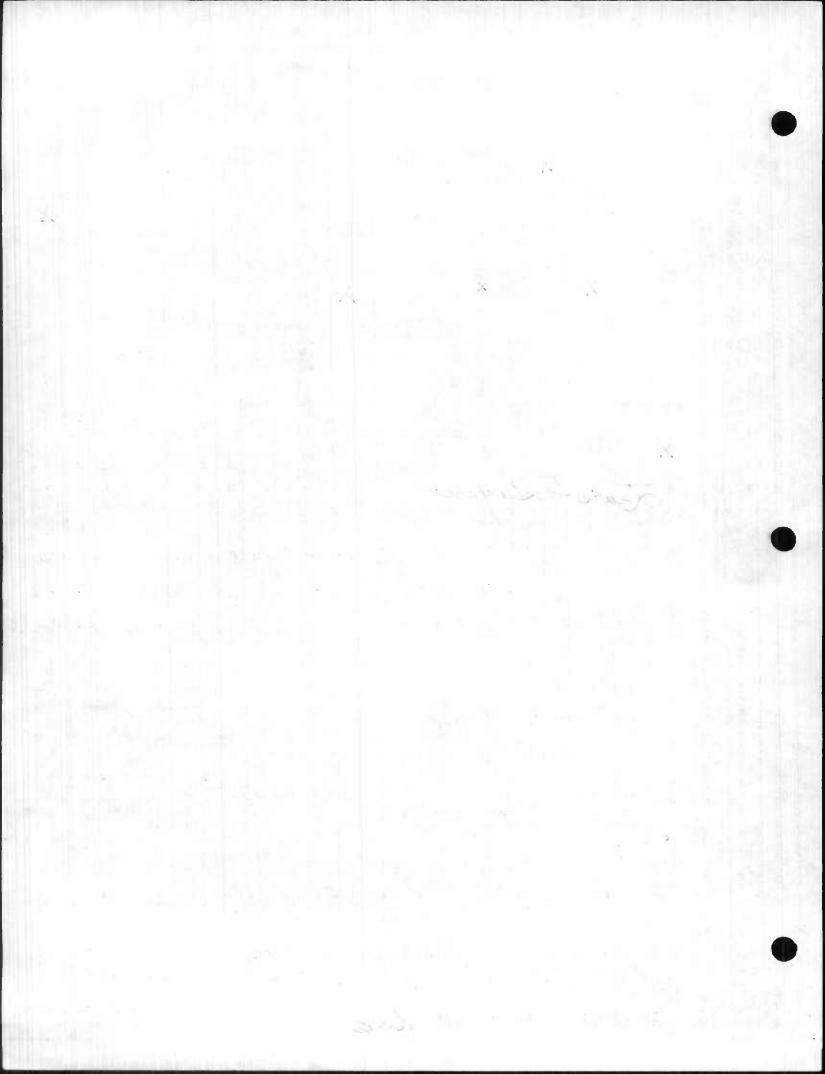
Rolling Green Rd CHUNCHULE, MP 21028

1-00

29d. Dete signed (Month, Day, Year)

ORIGINAL

29c. License number



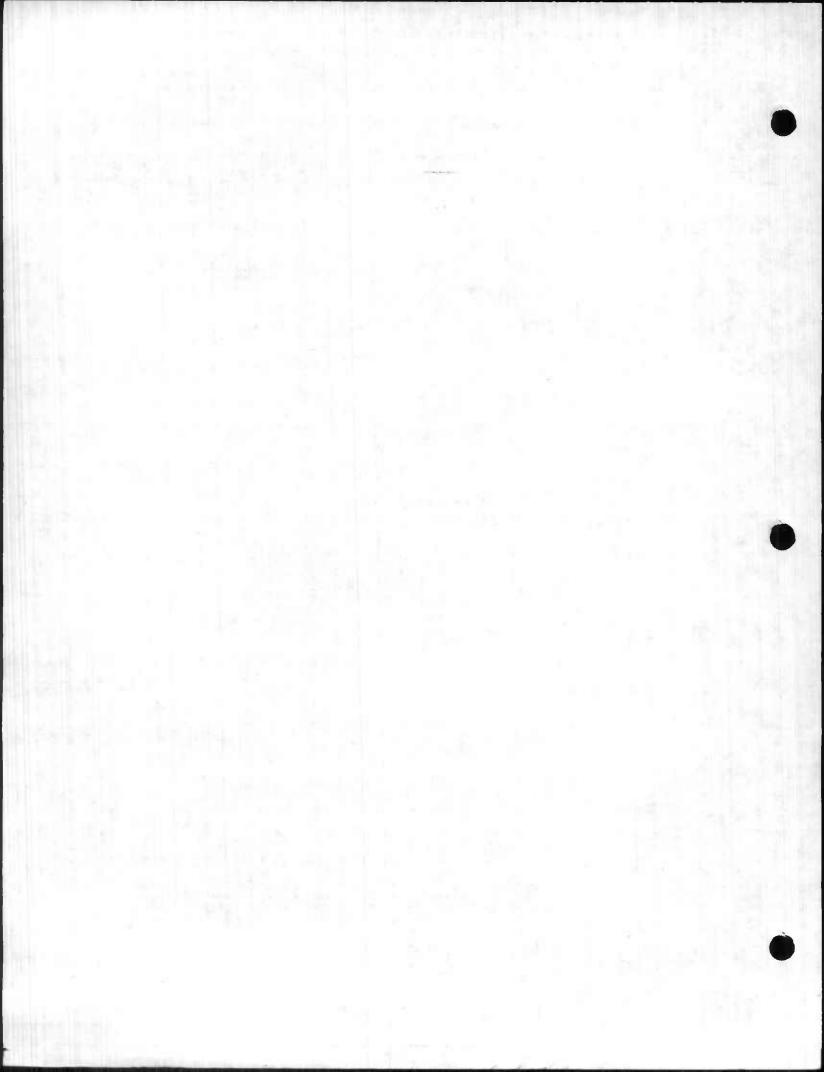
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

| WYLIE | State of Maryland / Department of Health and M mended item #7 per th 9782 4/25/2000 ab Certificate of Death | 111 1171154 |
|--|--|--|
| McCROERY | amended item #7 per fh g782 4/25/2000 ah Certificate of Death 1. Decedent's Name (First, Middle, Last) | Reg. No. 2. Date of Death 3. Time of Death |
| Physician | INTITION FOR MICH OF THE | JANUARY 25,2000 5:16P.M. |
| /Medica Examine | de City Town or I | |
| | 700 BLK. N.CAREY STREET BALTIMOR | |
| Funeral | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 1 17 / 11 73 53 | 8. Dete of Birth. (Month, Day, Year) 9. Birthplace (State or Foreign Country) |
| Director | Usuel Residence of Decedent | JAN. 26, 1956 MARYLAND |
| yland M M | 10a. State 10b. County 10c. City, Town or Location | 10d. Inside City Limits |
| n the Marylar r 28a-f show undiffied at | MARYLAND N/A BALTIMOK | ECITY 12 Yes 2 No |
| E 0 % (| 10e. Street and Number 10f. Zip Code | 10g/Citizen of What Country? |
| | | |
| har death v | 11. Maritel Stetus 12. Was Decedent Ever in U,S. Armed Forces? 1 Never Merried 2 Merried 1 Yes 2 No 1 Yes, specify Cuben, Mexican, Puerlo | Ricen, etc.) Black, White, etc. |
| 020 | 3 ☐ Wildowed 4 ☐ Divorced If Yes, Give 1 ☐ Yes 2 ☐ No Specify: Yeer or Detes: | Specify: BLACV |
| 1 21215-0 ad within 72 ho sypiene. ser than "ristur n. the Medical. | 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of work) | 16b. Kind of Business/Industry |
| 121 Man | Elementary/Secondery (0-12) Coilege (1-4or 5+) | |
| | | SELF-EMPLOYED (First, Middle, Maiden Sumeme) |
| ylanc | 11-00 | EE JONES |
| any show | 19a. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural) | |
| and 2 and 2 outh 1 or tra | MONYETTE SMITH (SISTER) 3925 BONNER ROA | D, BALTIHORE, MA 21216 |
| Ore Oresis | 20a. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, crematory or other piece) | Date 20c. Location - City or Town, State |
| timen tant | 4 □ Donetion 5 □ Other (Specify) MT. ZION CEMETERY O | POWN JR. FUNERAL HOME DAVE. BALTIHORE, MD 21217 |
| Ball Department of the services | 21. Signeture of Funeral Service Licensee 22. Name end Address of Fecility TO SE PH H. | ROWN JR. FUNERAL HOME |
| | 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of | AVE. BALTIHORE, MD 2/2/7 prespiratory arrest. Approximate |
| Physician | shock, or heert failure. List only one cause on each line. | Intervel Between Onset end Death |
| /Medical | Immediate Ceuse (Final disease or condition Gruns hot Wound | d lo Dack |
| Examiner | resulting In deeth) Due to (or es e consequence of): | |
| executed n and ial-transit | b | |
| 60, be executed sician and burial-transit | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | |
| 760 re be ysicia | Cause (Disease or injury that initiated events Due to (or es a consequence of): | |
| death certificate a strending phy of for use as the | resulting in deeth) Last | |
| P.O. Box 68 at the death certificate by the attending phetached for use as the backhed for use as the behalf of the second for | d | |
| the deay the a | Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. | 23b. Did tobacco use contribute to the cause of death? |
| E X D . | | 1 Yes 2 No 3 Probably 4 Unknown |
| Records, | | 24a. Wes en autopsy performed? 24b. Were autopsy findings available prior to |
| The law requir | | performed? available prior to completion of cause of death? |
| The Land | | 1 S Yes 2 □ No 1 S Yes 2 □ No |
| Vital I | 25. Wes case referred to medical axaminer? | (Check only one) |
| hy hy | A CONTRACTOR OF THE CONTRACTOR | me 5 Residence 6 Nother (Specify) SCENE |
| | 27. Menner of Death 1 Naturel 28a. Date of Injury (Month, Dey Year) 1 Yes 2 I No | Subject Short |
| Division I or Attending after death. Director: After d in by the fune | 3 Sulcide 6 Could not be determined 4 M Homicide 28et Place of Injury - At home, farm, street, factory, office (Found) | 28f. Location (Street end Number or Rurel Route Number, |
| DIV S after A M Director A | Street; Harlen and Carey S | Freet Baltimore, Md |
| DIVI he Hospital or At in 24 hours after he Funeral Direct pletely filled in by | 29e. Certifier (Check only (Ch | |
| the F | | 29d. Date signed (Month, Day, Year) |
| 0100 | 1 | |
| INT | 30. Neme and do less of person who completed ceuse of death (Item 23a) (Type, Print) | JANUARY 26,2000 |
| V | Ann I I | Baltimore, Maryland 21201 |
| State | 31. Dete filed (Month) Day, Year) 32. Registrer's Signeture | |
| Registra | IAN 2. 8 2000 Server & April 1 | |

DHMH 16 Rev 6/95

Fire 2 2 2004

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygier ? Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Dev Vest **Physician** JAN 0600 AM 2000 JACQUELINE MAE MILLER 25 /Medical 4e Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 6000 SAMARITAN HOSPITAL BALTIMORE If Under 24 Hrs. Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthdey) If Under 1 Year Birthplace (Stete or Foreign Country) **Funeral** Months Deys 10 M 20 F 66 JUNE 30, 1933 Director 213 -30-3875 MD Usuel Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d Inside City Limits 1 ☐ Yes 2FTNo Director MD BALTIMORE PARKVILLE 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 1504 U.S.A ANDERS ROAD 21234 Funeral Wes Decedent of Hispanic Origin? (Specify Yas or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Evar in U,S. Armed Forces? 14. Rece - American Indian, 11 Marital Status Bleck, White, etc. 1 ☐ Naver Merriad 2 ☐ Married 1 ☐ Yas 2 ☐ No 1 Yes 2 No Specify: à 3 ☑ Widowed 4 ☐ Divorced Yaar or Detes: WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Eiementery/Secondery (0-12) College (1-4or 5+) 12 HOMEMAKER 17. Father's Nema (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be 10 ELDER HILL JAMES DOROTHY 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Steta, Zip Code) PARKVILLE, MD. 21234
Dete 20c. Location - City or Town, Stete EDGEWOOD AVE. JAMES SHECKELS, SON 2609 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) JAN 28, 20e. Method of Disposition 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removei trom Stete 4 ☐ Donetion 5 ☐ Other (Specify) 2000 MORELAND MEM, PARK PARKVILLE, MD. 22. Neme end Address of Facility EVANS FUNERAL CHAPEL 21. Signatura of Funeral Sarvice Licensee RD. PARKVILLE, MO. 21234 8800 HARFORD Part Enter the disease, or periplications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, prock, or heart failure. Use only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final · METASTATIC LUNG CANCER diseese or condition resulting in death) MONTHS Examiner Due to (or as e consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequence of): Physician/Medical Due to (or es e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Dtd tobacco use contributs to the cause of death? 1 Yes 2 No 3 Probably 4 ☑ Unknown CIRRHOSIS à 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes en autopsy performed? 1 ☐ Yes 2 No 1 ☐ Yas 2 No 8 25. Was case reterred to medical examiner? 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) edical Certification: To 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Dete of Injury (Month, Dey Year) 27. Menner of Death 28b. Tima of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending 1 2 Neturel 1 ☐ Yes 2 ☐ No Investigation 2 Accident 6 Could not be determined 3 Suicide 28t. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, term, street, tactory, office building, etc. (Specify) 4 Homicide t/□ Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, and due to the ceuse(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) end manner stated.

The law requires that the death certificate be axecuted Box 68760 P.O. Records, Division of Vital Hospital or Attending Physician: after death

r 28a-f show unotified at

Items 23a or

'natural', or

Hygiene.

permit. Pages 1 and 2 should be filed of Department of Health and Mental Hygis reportant: If Item 27 is marked other 1

sloian and burial-transit

physician s the burial

signed t

director,

filled in by

this

After

death.

altimore, Maryland 21215-0020

within 24 hours a To the Funeral D completely filled ŝ 2

State Registrar

DHMH 16 Rev 6/95

EUZABETH 31. Dete tiled (Month, Dey, Year)

29e. Certifier

29b. Signature and title of certifier

NGUYEN

JAN 2 8 2000

MP

P12694

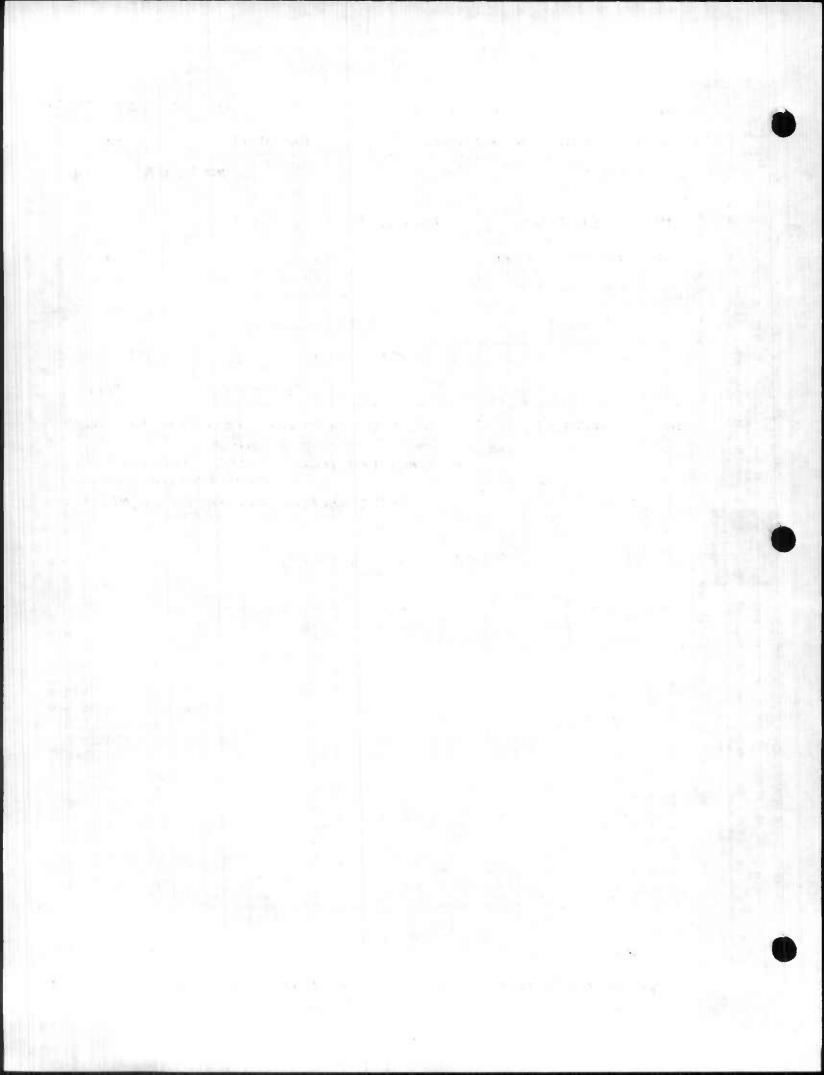
29c. License number

29d. Date signed (Month, Day, Year) 25,2000

30. Neme end address of person no completed cause of death (Item 23a) (Type, Print)

5601 LOCH RAVEN BUID. BALTIMORE, MD. 21239

MD 32. Registrer's Signeture Denni



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dev Month Yeer 705 PM MICHAEL J. MACKIN on of Death | Ic. County of Death 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Levindale Hebrew Geriatric Hospital Wing Baltimore # Under 1 Year | # Under 24 Hrs. | 8. Dete of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number Months 1 M 2 F 215-42-9671 Dec. 19, 1942 Md. Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Yes 2 No Md. Baltimore Towson 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 8 New Forest Ct. 21286 USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Merried 1 Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☑ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Sales Industrial Mechanics 17 Father's Neme (First Middle Last) 18. Mother's Name (First, Middle, Maiden Surname) Francis Μ. Mackin Catherine Gillooly 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant'a Name/Relationship (Type, Print) Towson, Md. Mrs. Margaret M. Ruth/sister 8 New Forest Ct. 21286 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Memorial 1/31/00 Timonium, Md 21. Signature of Funeral Service Los 22. Name end Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Deeth Immediate Cause (Final DAPU disease or condition resulting in death) ears Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thal initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23b. Did tobacco usa contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yea 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes en autopsy performed? 1 Yes 2□M6 1 ☐ Yas 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 DN6 2 ER/Outpetient 3 DOA

Physician /Medical Examine physician and the buriel-transit certificate be executed Box 68760, 087

Physician

/Medical

Examiner

Funeral

Director

25a-f show

8

"natural", or hems 23s

Hygiene. Hygiene. other then "n

permit. Pages 1 and 2 ahould be filled w Department of Health and Montal Hygien Important: if Nem 27 is marked other the any Injury or other transmissed other the

Director

Funeral

à

Completed

Be

P.O. signed b Division of Vitai Records, certificate sid After thi funeral To the Hospital or Attanding P. within 24 hours effer death.
To the Funeral Director: After ti completely filled in by the funera

Examiner Physician/Medical by Completed 89 Certification: To

DHMH 16 Rev 6/95

State Registrar

Medicai

5 Pending investigation

6 Could not be determined

29c. License number

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, dete end place, and due to the cause(s) and manner stated.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner as stated.

28c. tnjury al Work?

1 Yes 2 No

29d. Date signed (Month, Day, Year) Anuan 25

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HAROLD BOB Main 25 MD

28a. Date of Injury (Month, Day Year)

31. Date filed (Month, Day, Year)

27. Manner of Beath

1 DNatural

2 Accident

3 Suicide

29a. Cartifier

4 ☐ Homicide

(Check only one)

29b. Signature and title of certifier

JAN 28 2000

32. Jugintrur's Signature

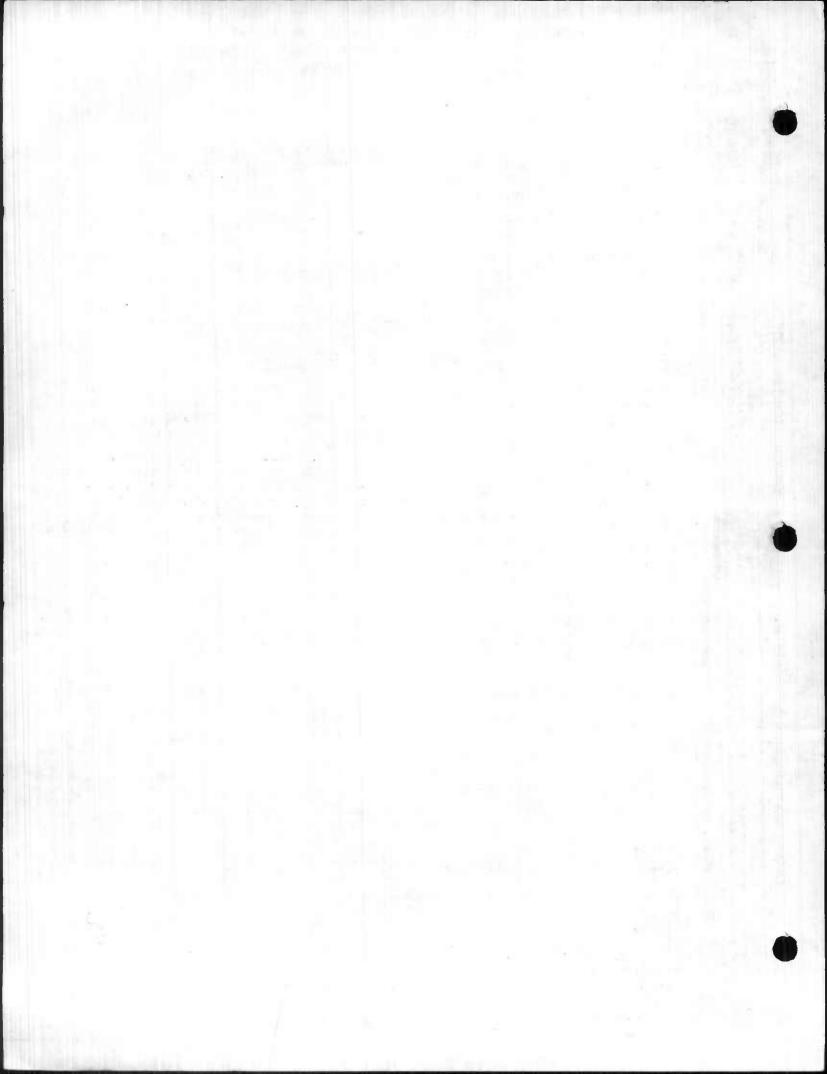
28b. Time of

28e. Place of Injury - At home, ferm, atreet, factory, office building, etc. (Specify)

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 12 15 7

| | | | Certificate of | Death | Reg. No. | 02001 | | | | | |
|--|---|---|---|--|---|--|--|--|--|--|--|
| | 1. Decedent's Neme (First, Middle, Las | 1) | | 2. Det | e of Death | 3. Time of Death | | | | | |
| Physician /Medical | | Anna M. | Moore | | | 2000 3:20 cm | | | | | |
| Examiner | 4e Facility Name (If not institution, give | street end number) | | 4b. City, Town, or Location of | of Death 4c. Coun | ty of Death | | | | | |
| | Franklin Square | Hospital C | enter | Rosedal | | Himore | | | | | |
| Funeral Director | 5. Social Security Number 6. Se 219–10–2774 | 7. Age (fn yrs. la. | st birthday) If Under 1 Yeer Months Deys | Hours Min. (Mo | e of Birth onth, Day, Year) . 26,1913 | 9. Birthplace (State or Foreign Country) Maryland | | | | | |
| | Usual Residence of Decedent | | | 11101 | . 20/2520 | 1 102 / 20110 | | | | | |
| Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23s or 28s-f ahow eny injury or other traumatic event, the Medical Examinar must be notified at pace. To Be Completed by Funeral Director | 10a. State 10b. County | | Town or Location | | | 10d. Inside City Limits | | | | | |
| 000 | Maryland Bal | timore | V | White Marsh | | 1 ☐ Yes 2 ☑ No | | | | | |
| be nounsed Director | 10e. Street and Number | | 10f. Zip Code | | 10g. Citizen of | What Country? | | | | | |
| 238 d | 5405 Bush Street | | | 21162 | Unit | ed States | | | | | |
| ner I | 11. Merital Stetus | 12. Wes Decedent Ever in U,S Armed Forces? | . 13. Wes Decedent of I | Hispanic Origin? (Specify Yean, Mexican, Puerto Rican, | s or No- | ce - American Indian, | | | | | |
| by Funeral | 1 Never Married 2 Merried | 1 ☐ Yes 2 ☐ No | 1 ☐ Yes 2 € No | | | ack, White, etc. | | | | | |
| þ | 30☐ Widowed 4 ☐ Divorced | If Yes, Give Yeer or Detes: | TLI Yes 26 No | Specify: | Speci | White | | | | | |
| Be Completed | 15. Decedent's Edi | ucation | 16a. Decedent's Usuel Occup | pation | 16b. Kind of I | Business/Industry | | | | | |
| ple | (Specify only highest grad | College (1-4or 5+) | (Give kind of work done life. DO NOT use retire | d) d) | | | | | | | |
| 0 | 7 Years | | Book Bind | er | Book | Bindery | | | | | |
| 9 | 17. Father's Neme (First, Middle, Last) | | | 18. Mother's Name (First, | Middle, Maiden Surne | Sumeme) | | | | | |
| ToB | John Berger | | | Kate Kle | ein | | | | | | |
| - | 19a. Informant's Neme/Reletionship (T | ype, Print) | 19b. Meiling Address (Street | 1 | | n, Stete, Zip Code) | | | | | |
| | Joyce DeVeau (Da | aughter) | 5405 Bush St | reet White M | Marsh, MD | 21162 | | | | | |
| | 20e. Method of Disposition | 20b. Ple | ce of Disposition (Neme of | Dete | 20c. Location | - City or Town, Stete | | | | | |
| | 1 Burial 2 □ Cremetion 3 □ I 4 □ Donetion 5 □ Other (Specify, | demover from State | netery, cremetory or other pleaney Valley Me | | 5/00 Timor | nium, Maryland | | | | | |
| 3 | 21. Signatura Funeral Service Licens | Sept O | 22. Neme end Addre | ess of Facility | Hama of Dundolly Inc | | | | | | |
| 8 | Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 2122 | | | | | | | | | | |
| | 7922 Wise Ave. Dundalk, Maryland 2 shock or hear bilder. List only one cause of each line. | | | | | | | | | | |
| ian | shock, or hear failure. List only o | ne cause on eech line. | • | | | Approximate Intervel Between Onset and Deeth | | | | | |
| cal | Immediate Cause (Finel | | | | | | | | | | |
| ner | disease or condition resulting in death) | 48 hours | | | | | | | | | |
| ē la | | Due to (or a | as e consequence of): | | | | | | | | |
| Medicai Examiner | | b. ————— | - V Carl V | | | | | | | | |
| × | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or e | es a consequence of): | | | | | | | | |
| <u>a</u> | Cause (Disease or injury thet initieted events | c | | | | | | | | | |
| 뮻 | resulting in death) Last | Due to (or e | es e consequence of): | | | | | | | | |
| by Physician/Medical Examir | d | | | | | | | | | | |
| - E | | | | | | | | | | | |
| Completed by Physician/P | Pert II. Other significant conditions co | ntributing to death but not result | ven in Pert I. 23 | 3b. Did tobacco use contribute to the cause of death | | | | | | | |
| F | Hypertension, | amostin No | and Indiana | 3 Probably 4 Unknown | | | | | | | |
| leted by | Hyperici sion, C | widesing HE | | 24h Mara autana findina | | | | | | | |
| ted | Peptic ulcer | Disease | | 24 | e. Was an eutopsy performed? | 24b. Were autopsy findings available prior to | | | | | |
| To Be Comple | TENTIC VICET | Wiserrae. | | | completion of cause of death? | | | | | | |
| 00 | | | | | 1□ Yes 2 No | 1 ☐ Yes 2 ☐ No | | | | | |
| Be | 25. Was case referred to medical | | | 26. Piece of Deeth (Chec | eeth (Check only one) | | | | | | |
| To E | examiner? | Hospitel: 1 phpatient 2 E | R/Outpatient 3 DOA Oth | | | ther (Specify) | | | | | |
| | 27. Manyter of Death | | 8b. Time of 28c. Injur | | escribe how injury occu | | | | | | |
| Certification: | 1 Neturel 5 Pending investigation | (monus, Day 1881) | | Yes 2 □ No | | | | | | | |
| by the fune | 3 Suicide 6 Could not be determined | 28e. Plece of Injury - Al hom | e, ferm, street, fectory, office | 28f. Loc | cation (Street and Nun | nber or Rural Route Number, | | | | | |
| e | 4 Homicide | building, efc. (Specify) | | Car | y or Town, State) | | | | | | |
| 0 | 29e. Certifier Certifying Phy | sician: To the best of my knowle | edge, deeth occurred et the tir | me, date end place, and due | to the cause(s) and n | nanner as stated | | | | | |
| edical | (Check only 2 Medical Exami | ner: On the basis of examinetio end manner stated. | n and/or Investigation, in my o | ppinion, deeth occurred et th | e time, dete and place | , and due to the cause(s) | | | | | |
| Medical Certi | 29b. Signeture and title of certains | | 29c. Licens | se number | 29d. Dete sign | ed (Month, Day, Year) | | | | | |
| | · // · // | 1 | | | | | | | | | |
| | year of Ar | nowing | | 16478 | Januar | 123,2000 | | | | | |
| | 30. Neme and address of person who co | | | | | 2.227 | | | | | |
| | DR Pedro Amada | | in Square brive | e localtimore | mary kno | 21237 | | | | | |
| State | JAN 2 8 200 | 32. Registrer's Signetu | | | | | | | | | |
| egistrar | AHIA Y O TOO | Deneva | D Spark | 2 | | | | | | | |



Registrar

State

DHMH 16 Rev 6/95

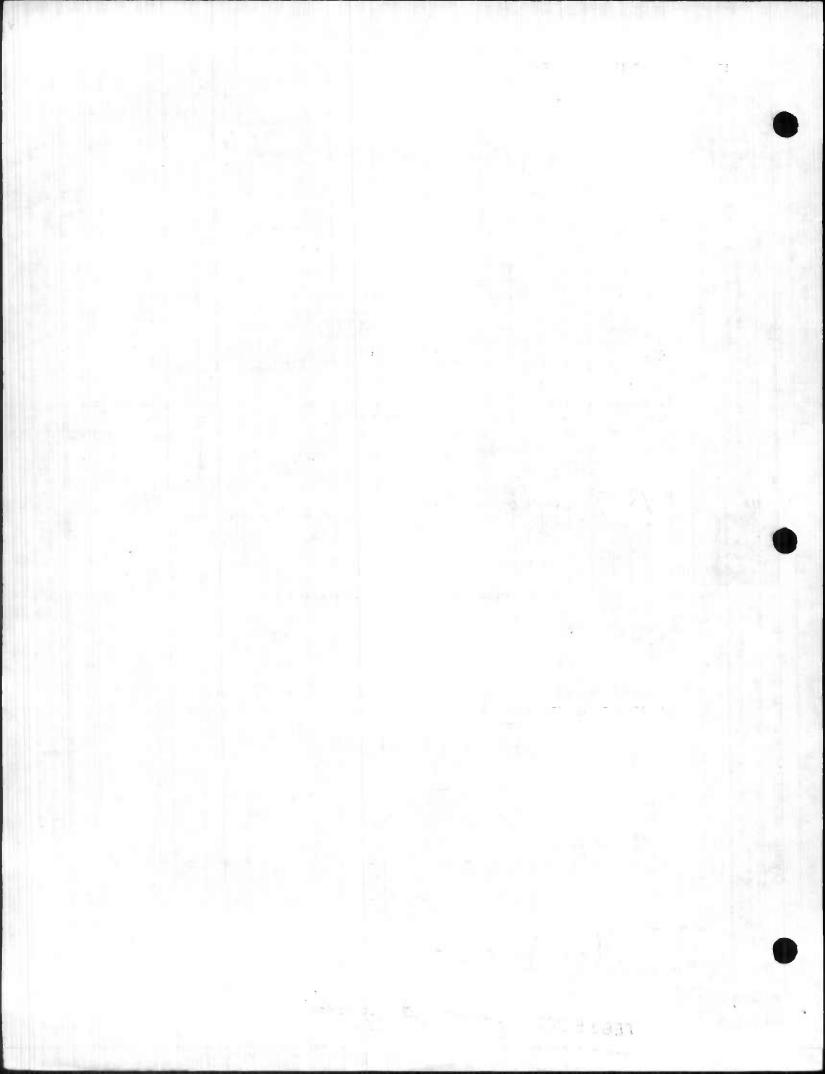
JAM

**** * * * ***

FEB 1 5 2000

DR. STephen
31. Date fited (Month, Day, Year)

2. Registrar's Signature



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year 12.10 Am CARROLL MONDSHOUR JANUARY 27 2000 4a Facility Nama (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death HARBOR CENTER BALTIMORE HOSPITAL H Under 24 Hra. 8. Date of Birth Hours Min. (Month, Day, Year) 5. Social Security Number If Under 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) 6. Sex Months Days 1 M 2 □ F 216-10-0081 April 18 1914 Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Yes 2 □ No n/a Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 649 E. Clement Street 21230 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: Specify: white 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Cab Driver Private Industry 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Cleveland Mondshour Genevieve Uzel 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James A. Mondshour (Son) 649 E. Clement Street, Baltimore, Md. 21230 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Glen Haven Memorial Park 1/31/00 4 Donation Glen Burnie, Md. 5 Other (Specify) 21. Signature of Funeral Servica Licensee 22. Name and Address of Facility McCully-Polyniak Funeral Home P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final SEPSIS 5 DAYS disease or condition resulting in death) Due to (or as a consequence of) NEMONIA Due to (or as e consequence of) Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 ☐ Unknown 1 Yes 2 No OBSTRUCTIVE PULMONARY DISEASE

Physician /Medical Examiner

physician and s the burial-transit

Box 68760,

P.O.

Records,

Division of Vital or Attending Physician: Examiner

Physician/Medical

Completed

Be

Certification: To

Medical

Physician

/Medical

Examiner

Director

Funeral

à

89

Funeral

Director

288-1

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flams 23a

natural, or

Hygiene.

permit. Pages 1 and 2 should be filed Department of Health and Montal Hygi-Important; if Isan 27 is marked other: any injury or other treumatic event. Its

Baltimore, Maryland 21215-0020

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. CONGESTIVE HEART FAILURE

24a. Was an autopsy performed?

26. Place of Deeth (Check only one)

28d. Describe how injury occurred

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No

1 ☐ Yes 2 No

25. Was case referred to medical 1 Yes 2 No 27. Manner of Death 1 Natural

28a. Date of Injury (Month, Day Year) 5 Pending investigation 6 Could not be determined

Hospital:

1 Inpatient 2 ER/Outpatient 3 DOA 28h Time of

28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 8 Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

2 Accident

3 ☐ Suicide

4 ☐ Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

JAN 2 8 2000

29c. License number P13483

2000 JANUARY 27

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3001 S. HANOVER STREET BALTIMORE MD 21225 CLARK, LEONIE

31. Date filed (Month, Day, Year)

32. Registrar'a Signature

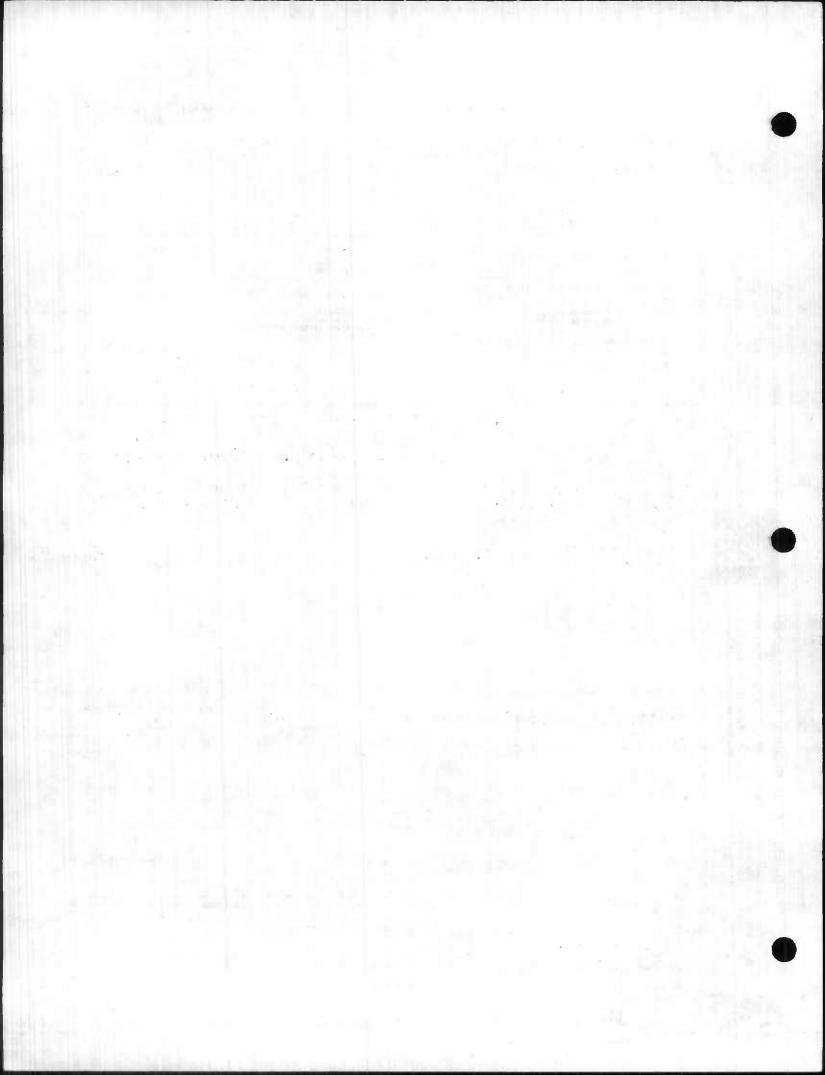
State Registrar

DHMH 16 Rev 6/95

To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After completely filled in by the fun

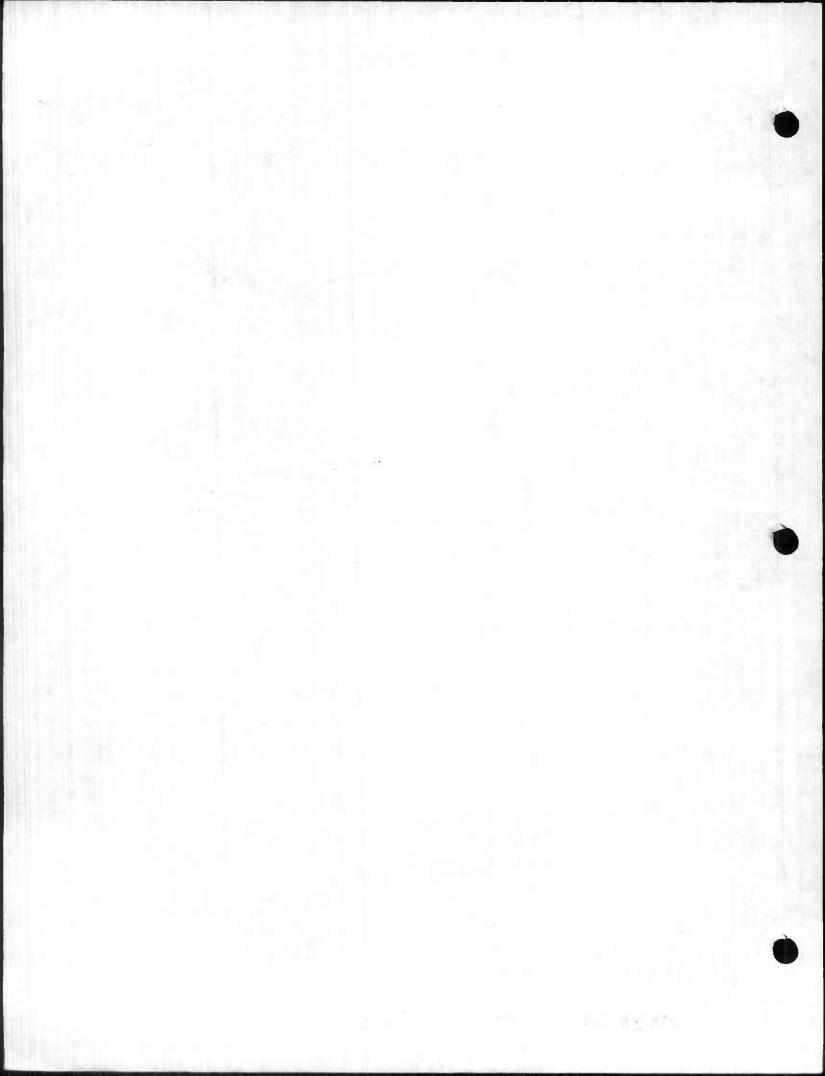
ORIGINAL



Please Type or Print in Black indelible Ink. Assure All Copies Are Legible.

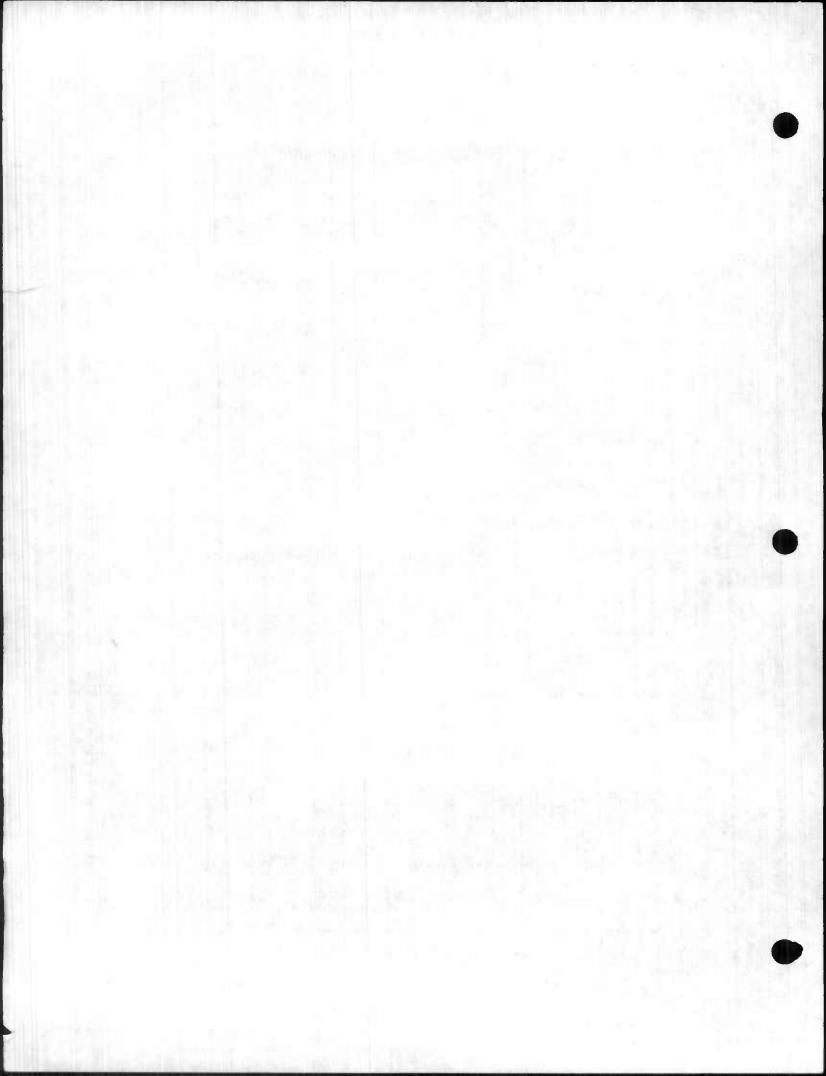
State of Maryland / Department of Health and Mental Hygiene

| | | | | Ce | rtificate of | Death | Re | g. No. | UZ | .000 | | | |
|---|--|--|---|--|--|--|---|--|----------------------------------|--------------------------------------|--|--|--|
| | | 1. Decedent's Nama (First, Middle, | | | | | 2. Dete of Death Month | 1 | Year | 3. Tima of Deeth | | | |
| | Physician /Medical | | BERTHA | ELIZABETI | H MURPHY | Y CALL | JAN 20 | 4000 | 1 oai | 5:00pm | | | |
| \$ | Examiner | 4a Facility Name (If not institution, | give street end number) | | | 4b. City, Town, or I | ocation of Deeth | 4c. County o | f Death | | | | |
| 145 | | 127 Rodeo (| ircle | | | Middle I | | | timor | | | | |
| | Funeral Director | 217-01-3476 | . Sax 7. Age (| In yrs. last birthday) 89 Yrs. | Months Days | | (Month, Dey. | Year) 910 | | ce (State or Foreign y) cyland | | | |
| pu | | Usual Residence of Decedent 10a. Stete 10b. County | 1 | 0c. City, Town or Lo | ocation | | | | 100 | d. Inside City Limits | | | |
| with the Maryland | or 28a-f ahow be notified at Director | MD Balt | imore | , | | Middle R | | | | 1 Yas 2 No | | | |
| ath with th | | 10e. Street and Number 127 Rodeo (| ircle | | 10f. Zip Code | 21220 | | | SA | | | | |
| 21215-0020 d within 72 hours after death | rai', or items 234 Exercises must I by Funeral | 11. Marital Status 1 □ Nevar Married 2 □ Merrie 3 ☑ Widowed 4 □ Divorced | 12. Wes Decedent Even Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yaer or Detas: | | Wes Decedent of I If Yes, specify Cub 1 ☐ Yes 2 2 No | Hispanic Origin? (Sean, Maxican, Puart | pecity Yas or No- o Rican, etc.) | | - Amaricar , White, et Whi | c. | | | |
| 5-C | ed within 72 houn ygiene. Ar then "netural" A, the Medical Ex Completed b | 15. Decedent's (Specify only highest | | 16e. Dece (Giva | dent's Usual Occu | petion during most of world) | king | 16b. Kind of Bus | iness/Indu | stry | | | |
| 121 vithin | then the | Elementery/Secondery (0-12) | College (1-4or 5+) | | |)d) | | | 7-1- | | | | |
| CA D | other than vent, pre- | 6th 17. Fathar's Nama (First, Middle, Lu | e#1 | C. | lerk | 18 Mother's Ner | ne (First, Middle, N | | Sales | 5 | | | |
| ⊆ 8 | Ih and Mental Hyg 7 Is marked othe traumatic event, To Be C | Charl | | | | | die Sent | | | | | | |
| Maryla 2 should | and le ma | 19e. Informent's Neme/Reletionshi | | | | t end Number or Ru | | | | (ode) | | | |
| C 1 | # W F | Bernice Ward | | | Rodeo Ci | | | Md. 212 | | | | | |
| E 68 | Y OF H | 20e. Method of Disposition 1 MBurial 2 Cremetion 3 4 Donation 5 Other (Spe | Li Hemovei from Steta | 20b. Place of Disponentery, cre LakeViev | metory or other ple v Cemeter | | Date 2 | Sykesv | | MD. | | | |
| Balti | | 21. Signatura of Funaral Sarvice Licensee 22. Name end Address of Fecility | | | | | | | | | | | |
| m & | 0599 | Connelly Funeral Home of Essex 300 Mace Ave. Baltimore Md. 21221 Approximation share caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval on set at the control of the cause of the | | | | | | | | | | | |
| // | ysician Medical caminer | Immediate Ceuse (Finel disease or condition resulting in death) | 4 | dionate conse | hic | pulma | | J. pro | 5,2 | niervel Between Onset and Death | | | |
| pennoe | sician and burial-transit | Sequentially list conditions, | b | e to (or es a conse | quence of): | | | | | | | | |
| 60, be axe | cian a burial- | Sequentially list conditions, If any, leeding to immediate causa. Enter Underlying Ceuse (Disease or Injury | | | | | | | | | | | |
| : 68760, rtificate be avacuted | as the | that initiated events resulting in deeth) Last | | Due to (or es e consequence of): | | | | | | | | | |
| Box | od by the attanding detached for use a Physician/M | | d | | | | | | | | | | |
| O. the de | the a | Part II. Other significant conditions | contributing to death but r | not resulting in the u | inderlying cause gi | iven in Pert I. | 23b. Did to | bacco usa cont | tributs to t | the cause of death? | | | |
| P. hat th | d by detac | Chansi | 1 Yes 2 No 3 Probably 4 Unknow | | | | | | | | | | |
| Records, P.O. Box | been significantly be seed by | Chronic Obstructive ful monay di | | | | | | 24a. Wes en autopsy performed? 24b. Were sutops availeble pric completion of | | | | | |
| I Rec | ge 2 | | | | | | 400 | 0.771 | | eath? | | | |
| - F | ficate or, pa | 25. Was case referred to medical | | | | OC Plans of Pas | 1 🗆 Ye | No. of Particular | 10 | Yes 2□ No | | | |
| Vital | Physician: The law this certificate has trail director, page 2 strail director, page 3 strail director, page 4 strail director, page 5 strail director | examiner? | Hospitel: 1 ☐ Inpatient | 2 ☐ ER/Outpatie | nt 3 DOA OI | her: | | th (Check only one) ome 5 □ Residence 6 □ Other (Specify) | | | | | |
| P P | 플을 누 | 27. Menner of Deeth | 28e. Dete of Injury | 28b. Time o | | | 28d. Describe ho | | | | | | |
| Vision | ath. e funer e funer atlon | 1 Natural 5 Pending 2 Accident Investige | (Month, Dey Y | ear) Injury | | Yes 2 No | | | | | | | |
| Division if or Attending | after death. Director: A d in by the fu | 3 Suicide 6 Could no determin | 28e. Plece of Injury building, etc. (| - At home, ferm, st Specify) | reet, factory, office | | 281. Location (Street and Number or Rural Route Number, City or Town, Stete) | | | | | | |
| Hospita | within 24 hours after death. To the Funerel Director: After the completely filled in by the funers Medical Certification: | | Physician: To the best of raminer: On the basis of each menner state | aminetion end/or in | | | | | | | | | |
| or to | To the comp | 29b. Signeture and title of certifier | hran | MI | 29c. Licen | se number | 29 | 9d. Date signed | (Month, D | ley, Year) | | | |
| | 0 | 30. Neme and address of person w | no completed cause of deer | th (Item 23a) (Type, | Print) | 1112 | 1. hnn | (15 A) | T. | 21011 | | | |
| | State | 31. Dete filed (Month, Dey, Year) | 32. Registrer's | Signeture | | 110 | 7 110 | | V 10 | X dd , | | | |
| | Registrar | JAN 28 2000 | peners. | D. Ap. | alle | | | | | 7.0 | | | |



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible,

| | 1. Decedent'a Na | me (First, Middle, L | ast) | | | | | 2. Date of De | | | Tima of Death |
|----------------------------|--|--|--|-------------------------------|--------------------------------|--------------|----------------------------------|-------------------------------|-------------------------------|-------------------|--|
| ian ical | | KENNE | TH | G | | MA | ARTIN | Januar | Day 7 25 20 | Year 200 5: | 10 P.M. |
| r | 4a Facility Name | (If not institution, g | iva street and number) | | | | 4b. City, Town, or | Location of Deaf | 4c. County | | -1-V -E |
| 9 | Harbo | r Hospita | 1 Center | | | Inder 1 Yea | Baltime ar Munder 24 Hr | ore | | N/A | |
| 1 | 5. Social Security 183–42 | | Sex 7. Age 1 XM 2 ☐ F | e (in yrs. last 49 | | nths Day | | . (Month, Da | y, Year) | 9. Birthplace (| State or Foreign |
| - | Usual Rasidence | of Decedant | | 42 | | | | APR. IV | J, 1930 | | PA |
| | 10a. State | 10b. County | | | own or Location | 1 | | | | | side City Limits |
| Director | PA | | OMERY | RYDA | | | | | | | LI Yas 2(1) NO |
| | 10e. Street and N | red HOLL | OW ROAD | | 10 | f. Zip Code | 19046 | | 10g. Citizen of 1 | | J.S.A. |
| | 11. Marital Status | | 12. Was Decedent I | Evar in U.S. | 13. Was D | ecedent of | f Hispanic Origin? (| Specify Yas or No | - 14. Rac | ca - American Inc | |
| | | rried 2 Married | Armed Forcas? | | | | | rto Rican, etc.) | | ck, Whita, atc. | TUTUE |
| | 3 🗆 Widowed | 4 Divorced | If Yes, Give Year or Dates: | | 104 | es 2DAN | o Specify: | | Specif | y: VV | HITE |
| annihita a | (Sp | 15. Decedent's i ecify only highast g | Education rada completed) | 1 | 6a. Decedent's (Give kind o | of work don | e during most of w | orking | 16b. Kind of B | usiness/Industry | |
| | Elementery/Sec | | College (1-4or 5 | i+) | iiie. DO N | | red) EARCH CON: | SIII.TANTS | SEARCE | H COMPAN | IV |
| - | 17. Father's Name | a (First, Middle, Las | | | | | 1 | ame (First, Middla | | | |
| | LOUIS | | | | MARTI | N | JOYCE | | | HIRSHON | |
| | | Name/Relationship | | | | | et and Number or F | | | | 9) |
| | | ES MARTIN | / WIFE | | | | LLOW ROAL | 1 | | | |
| | 20a. Method of Di | | XRamoval from State | came | of Disposition | or other p | | Data | | - City or Town, S | |
| | 4 Donation | 5 ☐ Other (Spec | city) | SHAL | OM MEMO | | | 1/27/00 | LOWER N | ORELAND | , PA |
| | 21. Signature of I | Funeral Service Lice | ensee C |) | | | frass of Facility | | | & BROS. | |
| | 23a Darit Enter | the disease or as | mplications Mat odused | I the death T | | | STERSTOWN | | | | 21208 roximate |
| ner | Immediate Cause disaase or condit resulting in death | tion | 8 | | rotic C | | vascular | Disease | | | |
| Examiner | Sequentially list of any, leading to | conditions, immediate | b | Due to (or as | a consequence | a of): | | | | | |
| Ca | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): | | | | | | | | | | |
| Completed by Physiclan/Med | | | d | | | | | | | | |
| SICIE | Part II. Other sign | nificant conditions | contributing to death bu | ut not resultin | g in the underly | ing cause | given In Part I. | 23b. Did | tobacco use co | ontribute to the | cause of death? |
| y ry | | | | | | | | 10 | Yes 2□ No | 3 Probably | 4 ⊠ Unknown |
| 2 | | | | | | | | 24a. Was | an autopsy | 24b. Were as | utopsy findings e prior to |
| piet | | | | | | | | | ection | complet | evailable prior to completion of cause of death? |
| | | | | | | | | _ | Yes 2X No | 1 ☐ Yes | 2 No |
| 2 | 25. Was case reference? | erred to medical | 11 | | | | | eath (Check only | one) | | |
| 2 | 1(X) Yes 2[| | Hospitel: 1 Inpatie | | Outpatient 3 | J DOA | | Home 5 Res | | | |
| | 27. Menner of De | eth 5 ☐ Pending investigati | 28a. Dete of Injur (Month, De) | y Year) 28 | b. Tima of Injury M | 28c. In W | ljuryat Vork? □ Yes 2 □ No | 25d. Describe | how injury occu | 1190 | |
| TION | 2 ☐ Accident 3 ☐ Sulcide | 6 ☐ Could not | be 28e. Place of Inju | ury - At home c. (Specify) | | | | 28f. Location (City or To | Street and Num. wn, State) | ber or Rural Rou | ste Number, |
| ertification | 4 Homicide | 29a. Cartifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| ical Certification | 29a. Cartifier (Check only | 1☐ Certifying F | | | | | | curred at the time. | dete end piece. | and dua to the | cause(s) |
| Medical Certification | 29a. Cartifier (Check only one) | 1☐ Certifying F | Physician: To the best of aminer: On the basis of and manner sta | examinetion | | ation, in my | y opinion, death oc | curred at the time, | | | |
| Medical Certification: | 29a. Cartifier (Check only | 1☐ Certifying F | miner: On the basis of | examinetion | | ation, in my | y opinion, death oc | curred at the time, | 29d. Date signe | ed (Month, Day, | Year) |
| Medical Certification | 29a. Cartifier (Check only one) | 1 Certifying F 2 Medical Exu | miner: On the basis of | examinetion ated. | and/or investig | ation, in my | y opinion, death oc | curred at the time, | 29d. Date signe | | Year) |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death Month Margaretta May Maddox 2000 22 12:45 PM January 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Multi-Medical Nursing Home Towson Baltimore 5. Social Security Number 6 Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Deys 1□M 2\ F Months Hours 218-01-4293 86 1913 March 31 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Baltimore Maryland Kingsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21087 7131 New Cut Road United States 11 Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Bleck, White, etc. 1 ☐ Yes 2 🏋 No If Yes, Give Yeer or Detes: 1 Never Merried 2 Merried 1 ☐ Yes 2 No Specify White 3 Nidowed 4 Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) House Mother Home for Girls 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) William David Caltrider Bertie Blanch Rodgers 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) R. Wayne Maddox (Son) 7131 New Cut Road Kingsville, Maryland 21087 20e. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete Dete 1 Burlal 2 □ Cremetion 3 □ Removel from Stete 4 □ Donation 5 □ Other (Specify) 1/31/00 Rosedale, Maryland Gardens of Faith Cemetery 21. Signeture of Funeral Service Licensee 22. Name end Address of Fecility Mitchell-Wiedefeld Funeral Home, Inc. twa T. Bottle 6500 York Road Baltimore, Maryland 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset end Death Immediate Cause (Final 1 week disease or condition resulting in death) Que to (or es e consequence of) eimer Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of) Due to (or as e consequence of) Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an eutopsy performed? 1 Yes 2 No 1 ☐ Yas 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospitel: Other: Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Netural 5 Pending Investigation 1 TYes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 281. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and menner stated.

Examiner Box 68760 P.O. Records, Division of Vital or Attending To the Hospinal Within 24 hours after deaf To the Funeral Director

Physician

/Medical

Examiner

Funeral

Director

ms 23s or 28s-f show must be notified at

or thems 23s or

filled within 72 hours after Hygiene. Then "natural", or the

permit. Pages 1 and 2 should be illed w Department of Health and Mental Hygien Important: if Nem 21 is marked other this any Injury or other the

Physician /Medical

physician and the burial-transit

3

has page 2

certificate

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After

after death.

signed to

Baltimore, Maryland 21215-0020

Directo

Funeral

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Completed

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Examiner

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Certification: To

edical

29e. Certifier

(Check only one) 29b. Signeture and the older

Yaul

the Maryla

State Registrar

DHMH 16 Rev 6/95

31. Date filed (Month, Day, Year) JAN 2 8 2000

M.D. Schwart 32. Registrar's Signature

30. Name and eddress of person who completed entile of death (Item 23a) (Type, Print)

29c. License numbe

29d. Date signed (Month, Day, Year)

2000

Hondilva



| | | | | | Certificate | | nd Mental | Reg. I | UU | 02 | 063 | | | | |
|--|---|--|--|---|--|--|---|---|--|--|---|--|--|--|--|
| ysician | 1. Decedent's Neme (First, Middle, | | | | . == | | 2. Date of Month | | Day | 3. Time of Death | | | | | |
| Medical | FREDERICK FRANCIS MUELLER JANUARY 25 2000 | | | | | | | | | | 11:00AM | | | | |
| Examiner | 4a Facility Name (If not institution, | give street end numbe | er) | | | 4b. City, Tov | m, or Location of I | Death | 4c. County | of Death | | | | | |
| eral | 5. Sociel Security Number 216-10-0281 | | Age (In yrs. I | | Months D | TOWSC ear If Under 2 ays Hours | 4 Hrs. 8 Date of | Birth Day Xe Xer 29 | ar) ooo | 9. Birthplac Country Mary Li | ce (Stete or Foreign | | | | |
| Director | Usuel Residence of Decedent | | | | | | | | | rial y 1 | und | | | | |
| Director | 10a. State 10b. County Maryland Baltim | nore | | | 11ey | | | | | 10d | I. Inside City Limits 1 Yes 2 No | | | | |
| Sire | 10e. Street and Number 10f. Zip Code | | | | | | | 10g. (| Citizen of W | What Country | | | | | |
| | | | | 210 | 30 | | | USA | | | | | | | |
| Funeral | 11. Maritel Stetus | 12. Was Deceder Armed Force | 87 | S. | 13. Wes Decedent | of Hispanic Orig | in? (Specify Yes o | No- | | e - American k, White, etc | American Indian, | | | | |
| | | | X) M(o | | 1 ☐ Yes 2 💢 | | | | Specify | | | | | | |
| 1 69 | | Year or Detes | s: | | | A. Opoury. | | | Specify | Wh | ite | | | | |
| To Be Completed by | 15. Decedent's (Specify only highest) | Education grade completed) | | 16a. D | ecedent's Usuel O Give kind of work d | ccupation | of working | 16b. | Kind of Bu | usiness/Indus | stry | | | | |
| | Etementery/Secondery (0-12) | College (1-4o | or 5+) | 'À | fe. DO NOT use n | etired) | | | | | | | | | |
| | 12 | | | E | ngineer | | | - | | struction | | | | | |
| | 17. Father's Neme (First, Middle, La | • | | | | | 's Name (First, Mi | | len Sumem | 10) | | | | | |
| 10 | Louis Keller Mueller Mary | | | | | | | | | | | | | | |
| Fo | 19a. Informent's Neme/Relationship (Type, Print) 19b. Melling Address (Street and Number or Rural Route Number, City or Town, State, J. | | | | | | | | | | ode) | | | | |
| | Susan M. Aumann DTR 500 Wyngate Road Timonium Maryland 21093 | | | | | | | | | | | | | | |
| | 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or cemetery, cremetory or other plece) | | | | | | | | | City or Town | n. State | | | | |
| any injury or one | 1 ☐ Burial 2 ☐ Cremetion 3 | CO 14 01 1 | | amalan. | cremetory or other | nlecel | Date | 200. | | | ., | | | | |
| | 4 Donetion 5 ☐ Other (Spe | | (0 | | cremetory or other | plece) | | | | | | | | | |
| | | cify) | (0 | | Ridge C | rplece) emetery ddress ol Fecility | 1/27/0 Mitchell | 0 Pi -Wiede | ikesvi feld Fu | ille, I uneral I | Maryland Home Inc. | | | | |
| | 4 Donetion 5 □ Other (Spe | city) | na B | ruid | Ridge Constant American Ridge Constant American Ridge Constant Ridge Ridge Constant Ridge Rid | emetery oddress of Fecility rk Road | 1/27/0 Mitchell Baltimor | O Pi -Wiede e, Ma | ikesvi feld Fu | ille, uneral I nd 212 | Maryland Home Inc. | | | | |
| | 4 Donetion 5 Other (Spe 21. Sonature of Funeral Service Lic | omplication that causely one cruss on each | ed the deeth | ruid Do no | Ridge C 22. Neme and A 6500 Yo enter the mode of | rplece) emetery ddress of Fecility rk Road dying, such es c | 1/27/0 Mitchell Baltimor | O Pi -Wiede e, Ma | ikesvi feld Fu | ille, uneral I nd 212 | Maryland Home Inc. 12 | | | | |
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| ner | 23a. Part1. Enter the disease, or so shock, or heart feilure. List on Immediate Ceuse (Finel disease or condition resulting in death) | omplication that causily one cruse on each | ed the deeth line. | ruid Dono | Ridge C 22. Neme and A 6500 Yo enter the mode of | rplece) emetery ddress of Fecility rk Road dying, such es c | 1/27/0 Mitchell Baltimor | O Pi -Wiede e, Ma | ikesvi feld Fu | ille, uneral I nd 212 | Maryland Home Inc. 12 opproximate literval Between loset and Death / WEEK | | | | |
| aminer | 23a. Part1. Enter the disease, or so shock, or heart feilure. List on Immediate Ceuse (Finel disease or condition resulting in death) | omplication that causily one cruse on each | ed the death line. Due to (or | Do no | Ridge Construction of the Ridge Construction | rplece) emetery ddress of Fecility rk Road dying, such es c | 1/27/0 Mitchell Baltimor | O Pi -Wiede e, Ma | ikesvi feld Fu | ille, uneral I nd 212 | Home Inc. 12 pproximete iderval Between inset and Death | | | | |
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DHMH 16 Rav 6/95

CHAN 31. Dete filed (Month, Day, Year) Registrar

32. Registrer's Signeture

30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

670KNORTH

M. D.

CHARLES

STREET

29c. License number

053430

BALTIMORE

29d. Date signed (Month, Day, Year)

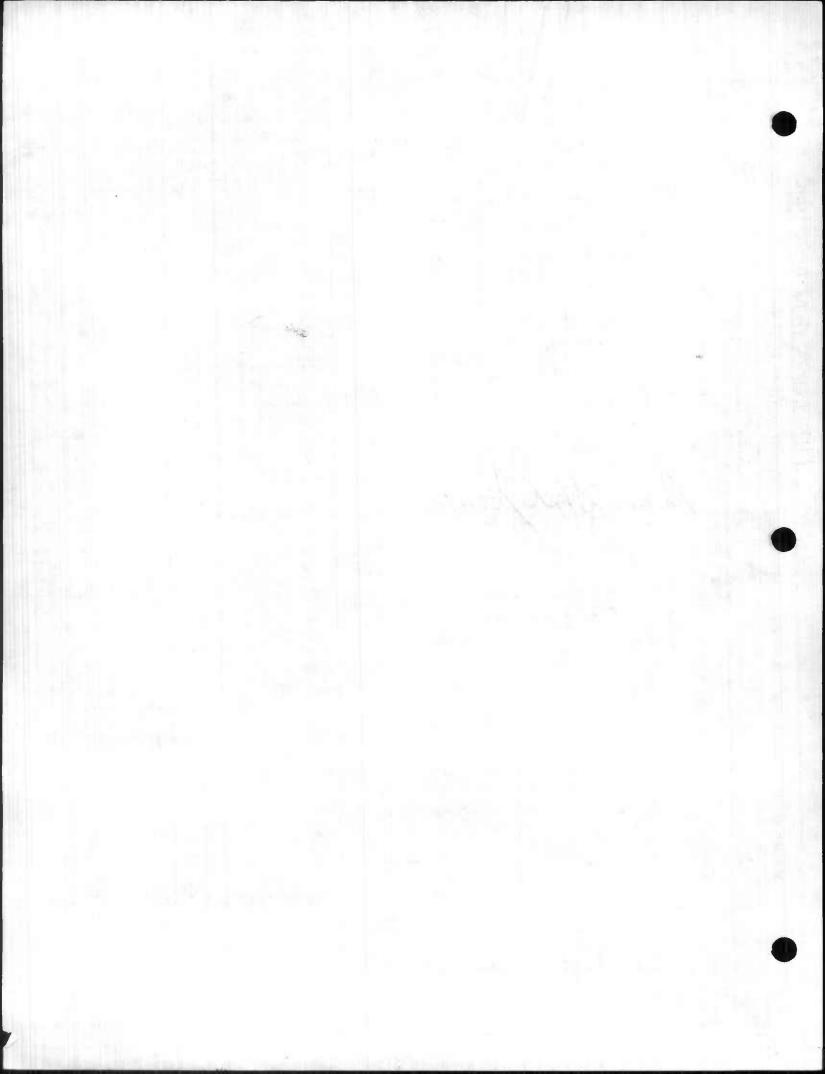
21204

JANUARY

MARYLAND

JAN 2 8 2000

29b. Signature end title ol certilier



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 3. Time of Death 2. Date of Death Month **Physician** MARY ELEANOR MCNAMARA 21 10:35 AM 2000 /Medical January 4c. County of Death 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Hospice of Baltimore: Gilchrist Center TOWSON If Under 24 Hrs. Hours | Min. Baltimore County 7. Age (In yrs. last birthdey) If Under 1 Year Months Devs 5. Sociel Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Deys 1□ M 2♥ F Director 216-466-3547 August 28, 1911 Maryland death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits met be notified at 1 ☐ Yes 2 📉 No Director Baltimore County Maryland Lakehurst. 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 12 Knoll Ridge Court 21210 USA Funeral Heme Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Meritel Stetus 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. filed within 72 hours after l ☐ Yes 2 No f Yes. Give 1 Never Merried 2 Merried 21215-0020 6 1 ☐ Yes 2 ☑ No Specify: Specify: þ White 3 Widowed 4 Divorced Year or Dates: Be Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Hygiene. 4 yrs Homemaker Own Residence Baltimore, Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be finent of Health and Mental Fint: If Item 27 is marked of Edward L. Flanigan Julia Nester 19e. Informent's Neme/Reletionship (Type, Print) 19b. Melling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. F. David McNamara (Son) 20e. Method of Disposition 20b. Place of Disposition (Name of camelery, cremetory or other place) Hunt Valley, Maryland 21030 Dete 20c. Location - City or Town, Stefe 1 XBuriet 2 Cremetion 3 Removel from State = 8 **Department** New Cathedral Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 1/24/2000 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road, Baltimore Maryland 21212 approximate the mode of dying, such as cardiac or respiratory arrest, triarval Between Onset and Death John O. Mitchell TV 23a. Part. Enter the disease, or complications that caused the deeth. Do not enter unlock, or heart feilure. List only one cause on each line. **Physician** /Medical Immediate Cause (Final CANCER nchamara, mary envs disease or condition resulting in deeth) Examiner Examiner The law requires that the death certificate be executed Sequentially list conditions, if eny, teeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Due to (or es e consequence of): Physician/Medical Due to (or es a consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? page 2 1 ☐ Yes 2 ☐ No or Attending Physician: funeral director, 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospitel: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No Medical Certification: To 2 ER/Outpatient 3 DOA this 28a. Dete of Injury (Month, Dey Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 5 Panding Investigation 1 Wetural 1 ☐ Yes 2 ☐ No 2 Accident death. after death Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Ptece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide Hospital 24 hours a Funeral D The Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner as stated. 2 Madicat Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29e. Certifier within 2 To the 29b. Signeture and affer of cy 29c. License number 29d. Date signed (Month, Day, Year) person who completed cause of deeth (ttem 23a) (Type, Print) Balto. 670 BMC 1 31. Dete filed (Month, Dey, Year) 32. Registrar's Signeture State

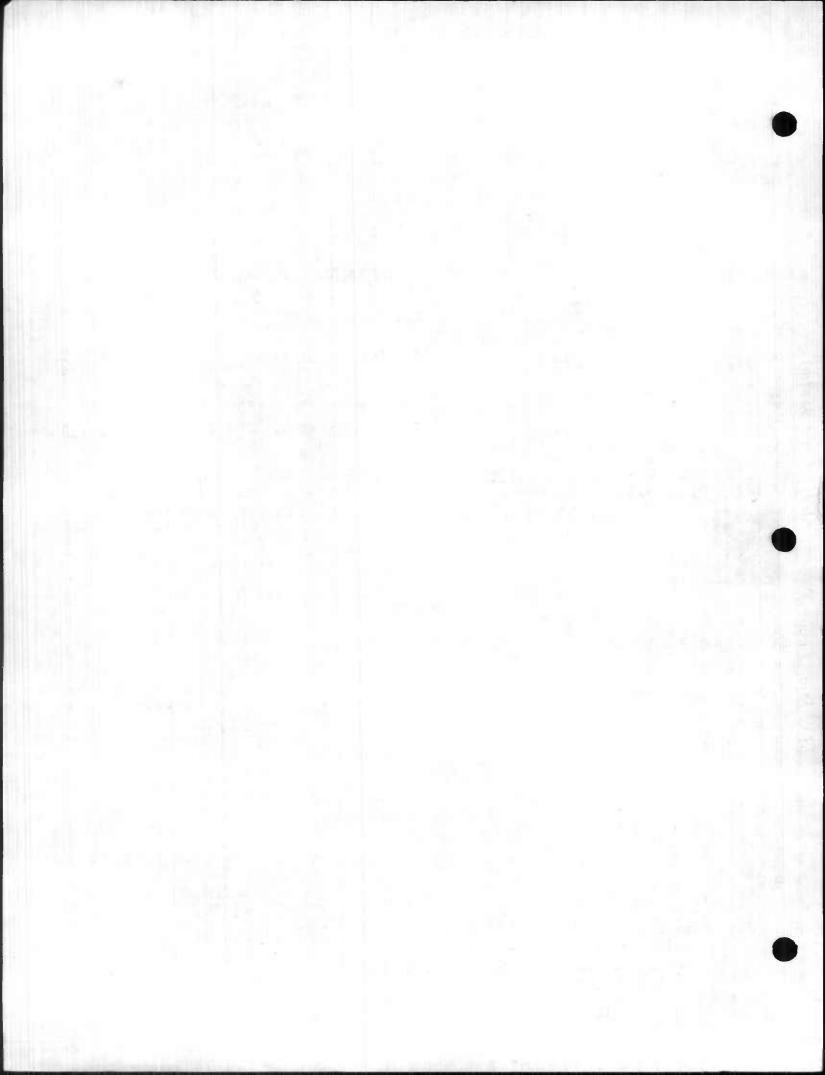
Registrar

DHMH 16 Rev 6/95

JAN 2 8 2000

21/00 10:35AM

ORIGINAL



Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMEND#20e PER F.H. G779 1-28-2000 J.A. Certificate of Death Reg. No. 1. Decedant's Name (First, Middle, Last) 3. Time of Death 2. Dete of Deeth Day Year Month 155 A **Physician** HUDRE MOORE 2000 /Medical 4a Facility Nama (If not institution, give street and number) 3H Gevictic Cti 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE Lakeside Missing Home N/A If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Aga (In yrs. last birthday) 6. Sex Birthplaca (State or Foreign Country) **Funeral** Months Deys 1□M 20€F Yrs. 93 07 Director 212-10-3205 MD 10 1906 Usual Rasidance of Decedent r 28a-f show 10a State 10b. County 10c, City, Town or Location 10d. Insida City Limits 1 Yes 2 No Middle River Directo Md Baltimore 10e. Straat and Number 10f. Zip Coda 10g. Citizen of What Country? "naturel", or items 23a or LANE 21220 USA West Kingston Park Avenue Funeral 12. Was Decedant Ever in U,S. Armed Forcas? 1 ☐ Yes 2 ■No If Yes, Giva Year or Datas: Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, etc.) 14 Race - American Indian Black, Whita, atc. Peges 1 and 2 should be filed within 72 hours effer or and of health and Mertell Pygiene.
It filem 27 is marked other than "naturel", or then iny or other traumatic avent, the Modified San institution of the traumatic avent, the Modified San institution of the Modified San institution or other traumatic avent, the Modified San institution of the Mo 1 □ Never Merried 2 □ Merried 1 Yas 2 No Specify: þ 3 Nidowed 4 Divorced white Completed 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 18. Mother's Nama (First, Middle, Maiden Surname) 17. Father's Nama (First, Middle, Last) Be Unknown Unknown 19a. Informent's Name/Ralationship (Type, Print) Grand 19b. Mailing Addrass (Street end Number or Rural Route Number, City or Town, State, Zip Code) Beverly Caporossi/daughter 24300 Airport Rd #111 Ponta Gorda,FL33950 20b. Place of Disposition (Name of cemetery, crematory or other placa) Crem 20a. Mathod of Disposition 20c. Location - City or Town, State Department of Important: If it eny injury or o 1 ☐ Burial 2 Cramation 3 ☐ Ramoval from State Baltimore Washington 4 ☐ Donation 5 ☐ Other (Specify) Laurel, Md. 01 25 22. Nama and Address of Facility 21. Signature of Funeral Sarvica Licensee Bradley-Ashton-Matthews Funeral Home, Tober 23a. Pert1. Enter the disaase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 21222 Approximate Interval Between Onset and Death Physician Dehydration /Medical Immediata Causa (Final 2 month disaasa or condition rasulting in daath) Examiner Due to (or as a consequence of): Examiner Alzheimer's disease physician and s the burial-transit Sequantially list conditions, if any, laading to Immadiata cause. Entar Underlying Cause (Disaese or injury that initiated avants rasulting in daath) Last Dua to (or as a consequence of): Physician/Medical Dua to (or as a consequence of) 23b. Did tobecco use contribute to the cause of death? ed by the Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown UTI signe 1 be d 2 24b. Wera autopsy tindings evallabla prior to completion of cause of daath? Completed 24a. Was an autopsy performed? Decubitus is certificate hes I 2 No 1□ Yas 2 No 1 Yas Be 25. Was casa ratarred to medical axaminar? 26. Pleca of Deeth (Check only one) Hospitel: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Rasidanca 6 Othar (Specify) 1 Yas 2 No 2 27. Mannar of Daath 28a. Dete of Injury (Month, Day Year) 28c. Injury at Work? 28b. Tima of 28d. Describe how injury occurred Certification: 1 Netural 5 Pending Invastigation 1 ☐ Yas 2 ☐ No 2 Accidant 6 Could not be datermined 3 Suicida 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, streat, factory, offica building, atc. (Specify) in by 4 | Homicida 29e. Cartifiar 1 Certifying Physician: To the best of my knowledga, daath occurred at tha time, data and placa, and dua to tha causa(s) and manner as stated. Medical

that the death certificate be executed Records, P.O. Box 68760, lew requires The Division of Vital Hospital or Attending Physician: To the Hospital or within 24 hours eft To the Funeral Di completely filled in

this

After

death.

efter deat Director:

the Meryland

with

deeth

State Registrar

31. Data filed (Month, Day, Year) JAN 28 2000

(Check only one)

29b. Signature and title of certifier

Sur

S. YASAR Johns Hopkins Geriatric Ctr, 32. Registrer's Signetura

ND

30. Nama and address of person who completed cause of deeth (Item 23e) (Type, Print)

201

Sparker

2 Medical Examiner: On the bests of examination and/or invastigation, in my opinion, death occurred at the time, deta end pleca, end due to the causa(s) and manner stated.

29c. License number

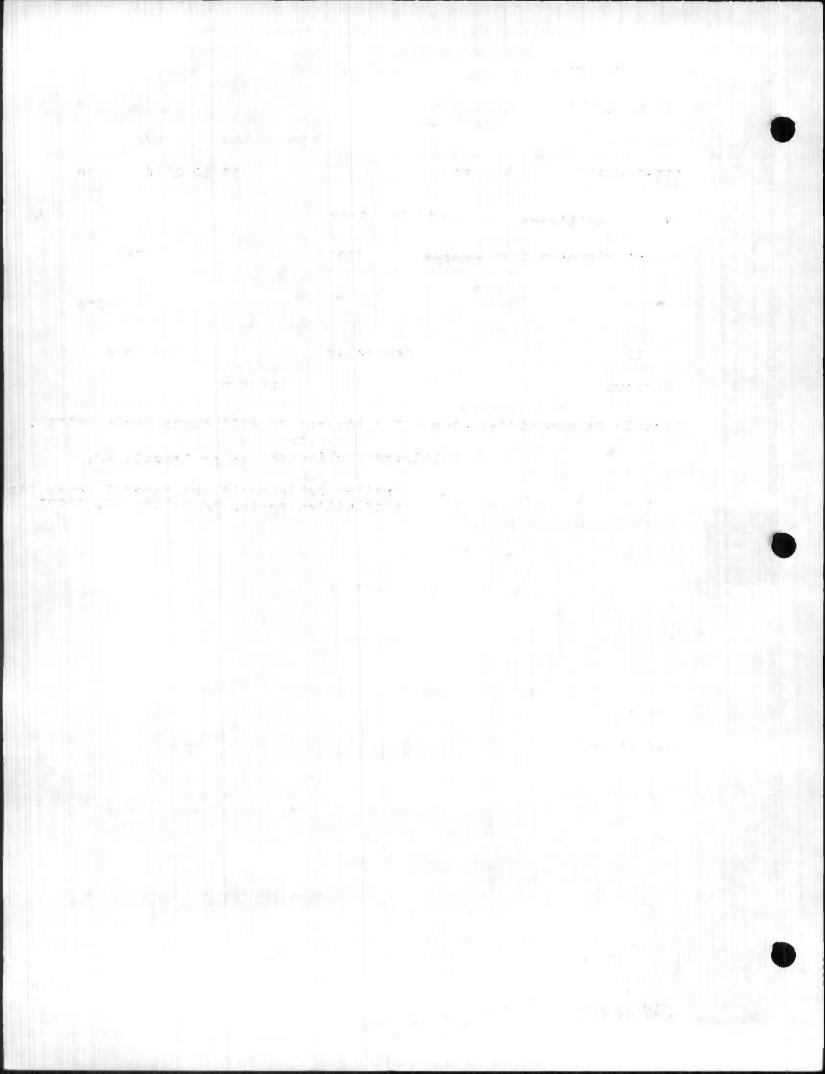
D 0054 067

29d. Data signed (Month, Dey, Year)

22,2000

January

5505 Hopkins Bayview Circle, Battimore 17D



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Tima of Death Month AM Dolores P. Murray 2000 JAA 4a Facility.Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death IMORE If Under 24 Hrs. If Under 1 Yes 5. Social Security Number 7. Age (In vrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Deys 1 M 20 F Months Hours 220-03-6792 July 23, 1918 MD. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No MD. Baltimore Baltimore 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 13 Holmes Avenue 21228 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11 Merital Status Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Merried 1 ☐ Yes 2 ☑ No Specify: white Specify: 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent'a Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) State of Md. dietary supervisor 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Charles Gallagher Mary Elizabeth Callery 19a. Informant'a Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Riesner, daughter 609 Coleraine Rd., Baltimore, Md. 21229 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location · City or Town, Stete 1 Burial 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cemetery 1/26/00 Baltimore, Md. 22. Name and Address of Facility
Witzke Funeral Home of Catonsville, Inc. 21 Signature of Funeral Service Licenses 1630 Edmondson Ave., Catonsville, Md. 21228 emmer 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart tailure. List only one cause on each line. Approximata Intervel Between Onset and Deeth Immediate Cause (Final disease or condition resulting in death) MONTH PIRATION NEUMONIA MONIT Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): HRONIC Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown 24b. Wera autopsy findings aveilable prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 Yes 1 ☐ Yes 2 ☐ No 25. Was casa referred to medical axaminer? 26. Place of Deeth (Check only one) Hospital: 110 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Rasidence 6 Other (Specify) 11 Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Netural 5 Pending investigation 1 □ Yas 2 □ No 2 ☐ Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Steta) Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide 29a. Certifier 📆 Certifying Physician: To the best of my knowledge, death occurred at the tima, date and place, end due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signeture and title of certifier 29d. Date signed (Month, Day, Year)

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within 24 hours a To the Funeral D DHMH 16 Ray 6/95

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Funeral

Director

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r than "natural", or items 23s or 28s-f show the Medical Examinar must be notified at

permit. Peges 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural, or Item any Injury or other traumatic avent, the Medical Essentiation."

Physician

/Medical

Examiner

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this certificate

death.

Physician/Medical

by

Completed

Be

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Certification:

Baitimore, Maryland 21215-0020

31. Date filed (Month, Day, Year) JAN 28 2000

CHARLES 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ORIGINAL

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienen Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dev Year 15 40 Facility Name (If not institution, give street and number) DODD 4b. City, Town, or Location of Death 4c. County of Deeth Northwest Hospital Randallstown Baltimore 5. Sociel Security Number 1 Year If Under 24 Hrs. Days Hours Min. 6. Sex 7. Age (In vrs. last birthday) If Under 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1□ M 2⊠ F Months 216-34-3022 64 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits Baltimore Catonsville 1 ☐ Yes 2 ☑ No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 31 Glenwood Avenue 21228 U.S.A. 11 Mental Status 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 Yes 2 No If Yes, Give X Yeer or Detes: 1 Never Merried 2 Married 1 ☐ Yes 2 ☒ No Specify: Specify: White 3 Widowed 4 Divorced 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. Do NOT use retired) Data Processing 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Book Printing & Elementery/Secondary (0-12) College (1-4or 5+) Distribution 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) William Nelson Mummert Blanche Lafferty 19e. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) MD 21228 111 Oella Avenue, Catonsville, Richard Johnson (Nephew) 20e. Method of Disposition 20b. Pleca of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stete Date 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete Balto. Washington Crematory 1/28/00 Laurel, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Fundrel Service Licansee 22. Neme end Address of Fecility Witzke Funeral Homes, Inc. 1630 Edmondson Avenue, Catonsville, MD 21228 23e. Pern. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart fellule. List only one cause on each line. Approximate Intervel Between Onset end Death Immediete Cause (Finel diseese or condition resulting in deeth) NOVI Due to (or as e consequence of): hickery Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest Due to (or as a consequence of): Due to (or es a consequence of): Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were sutopsy findings evallable prior to 24a. Wes an autopsy performed? completion of cause of death? 2 No 1 🗆 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 28. Plece of Deeth (Check only one) 1□ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28e. Date of Injury (Month, Dey Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Netural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be determined 3 Suicide

The law requires that the death certificate be executed Box 68760. P.0. Records, Division of Vital

Physician

/Medical Examiner

Funeral

Director

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r than "natural", or items 23s or the Medical Exercitives result be

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Funeral Director

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Completed

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filed within 72 hours after

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Pages 1 and 2 should be filed vient of Health and Mental Hygie mt: If Nem 27 Is marked other

nt of Health a : If Nem 27 la : or other tre

Department of Important: If any injury or phose.

Physician /Medical

Examiner

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page 2

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Examiner

Physician/Medical

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Completed

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21215-0020

Baltlmore, Maryland

certificate or Attending Physician: Tater death.

Director: After this certifications funeral director. Certification: To filled in by To the Hospital or within 24 hours at To the Funeral D Medical **Sompletely**

State Registrar

31. Dete filed (Month, Dey, Year) JAN

29b. Signature end title of certifier

4 Homleide

(Check only one)

29e. Certifier

32. Registrar's Signeture 11/4/2

28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

ORIGINAL

29d. Date signed (Month, Dey, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, Stele)

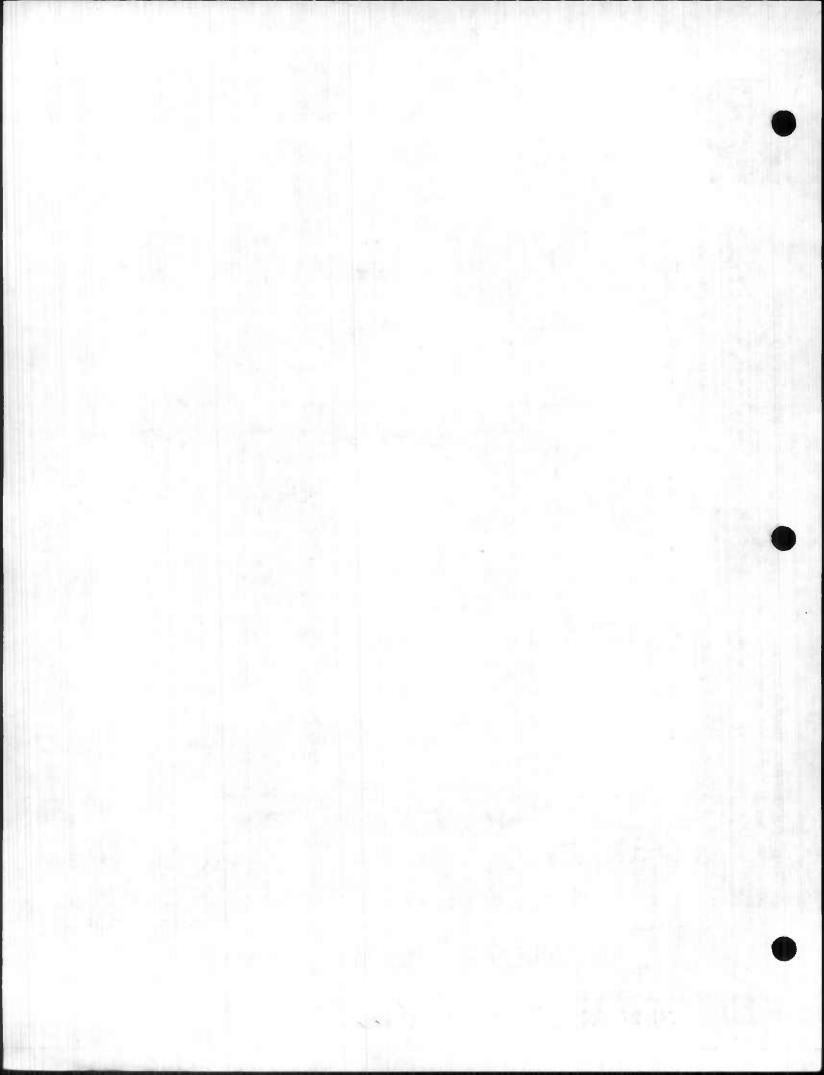
1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

2 8 2000

30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print)



Please Type or Print In Black Indelible Ink. Assure All Copies Are Légible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day CATHERINE A. MOORE JANUARY 21 2000 11_am 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death ROSEDALE If Under 24 Hrs. 8. D 903 CHESACO AVENUE BALTIMORE Birthplace (State or Foreign Country) If Under 1 Year 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. last birthdey) Months Days Min. Hours 1□ M 2♥ F 75 OCT 10 1924 MARYLAND 218142818 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 Yes 2 No BALTIMORE ROSEDALE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 903 CHESACO AVENUE 21237 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: 3 Widowed 4 ☐ Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) BOWLING 12 0 MANAGER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) CHARLES CONRAD LOUISE BERGER 19a. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) CONI MOORE / DAUGHTER IN LAW 903 CHESACO AVENUE ROSEDALE, MD 21237 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State HOLLY HILL CEMETERY 1/25/00 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 21 Signature of Funeral Service Licenses 1211 CHESACO AVENUE BALTIMORE, MD enio 21237 icanors that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ne cause on each are. 23a. Part1. Enter the disease, or complications shock, or heart tailure. List only one Approximate tnterval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Ccolo Due to (or as a consequence of) he. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings svallable prior to completion of cause of death? 24a. Was en eutopsy performed? 1 ☐ Yes 2 ☐ NO 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Hospitel: 1 | Inpatient Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Menner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 PNatural 1 TYes 2 No 2 Accident 6 Could not be determined 3 Suicide Location (Street end Number or Rurel Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

The law requires that the death certificate be executed signed by the attending physician and d be detached for use as the burial-transit Box 68760, Division of Vital Records, P.O. certificate has Attending Physician: After this or Attending after death. ne Hospital or Atta n 24 hours aftar de ne Funeral Directo sistely filled in by ti

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Hygiene.

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Completed

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Certification: To

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29a. Certifier

(Check only one)

29b. Signature and line of certified

funeral director,

compiately

7 is marked other traumatic event, I

altimore, Maryland 21215-0020

DHMH 16 Rev 6/95

To the Within 2

State Registrar

31. Date filed (Month, Day, Year) JAN 2 8 2000

9660 Belair Rd.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, MD. 21236

32. Registrar's Signature

doorte

1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

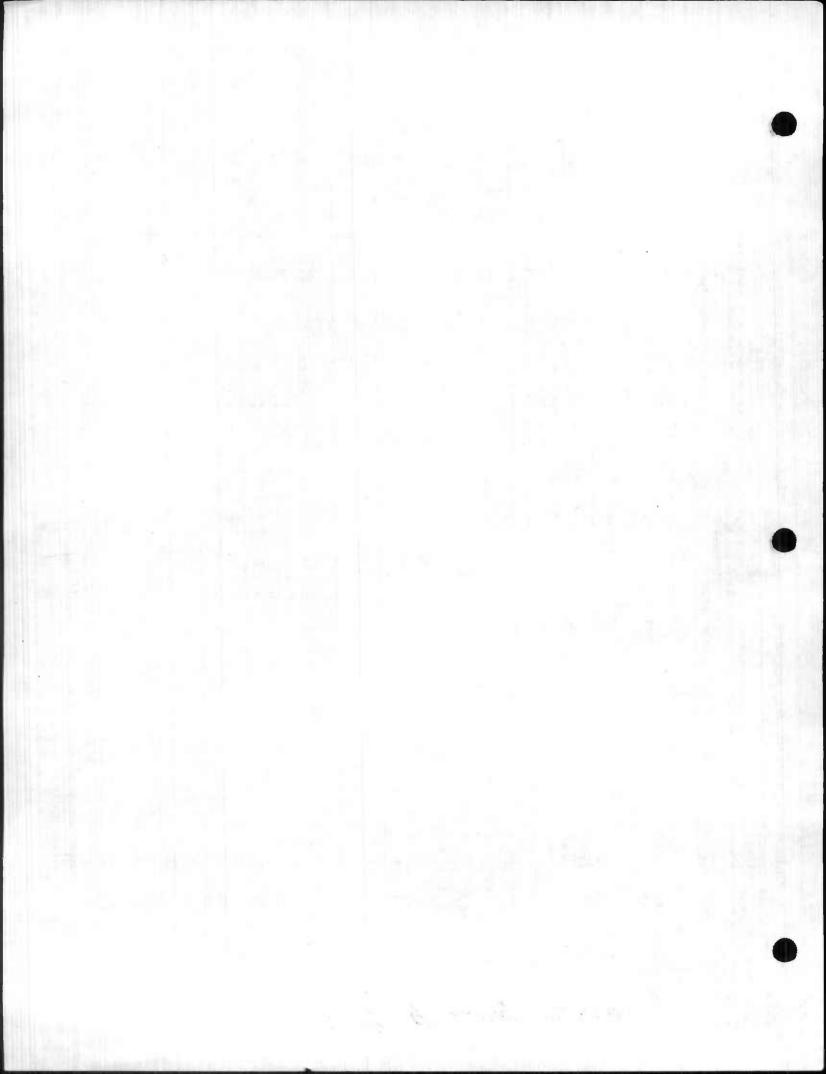
29c. License number

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29d. Date signed (Month, Day, Year)

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1/24



Please Type or Print in Biack Indelible ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

\(\int \) 02069 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death JANUARY 26, 2000 D **MERRYMAN** 11:35 P.M. 4a Facility Name (If not institution, give street and number HERITAGE CENTER, GENISIS 7232 GERMAN HILL ROAD 4b. City, Town, or Location of Death 4c. County of Death ELDERCARE BALTIMORE DUNDALK If Under 1 Year If Under 24 Hrs 5. Social Security Number 7. Age (In vrs. last birthday) Birthplaca (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Months Days Hours 1 ☐ M 2 🗙 F JUNE 13, 1924 MARYLAND Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No ANNE ARUNDEL MILLERSVILLE 10f. Zio Code 10g. Citizen of What Country? 299 DOGWOOD ROAD 21108 UNITED STATES 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yea or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🖔 No If Yes, Give 1 Never Married 2 Married 1 Yes 2 No Specify: WHITE Specify: 3X Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) NONE CUSTOMER SERVICE REP. LUCAS BROTHERS 17. Father's Name (First, Middle | Last) 18 Mother's Name (First, Middle, Meiden Surname) WIELEBSKI DONAVAN ANNA 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 7414 CHERRY TREE DR. CLARKSVILLE, MD 21029 CARL MERRYMAN/SON 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, crematory or other place) JAN. 29 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State 4 Donation (South) STANISLAUS CEMEMERY DUNDALK, MARYLAND 2000 21. Signature of Funeral Service Con SINGLETON FUNERAL HOME UE SECOND AVE. S.W., GLEN BURNIE, MARYLAND 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest shock, or heart failure. List only one ceusa on each line. Approximate Intervat Between Onset and Death ALZHEIMER'S SEMENTIA 5-6 grs Due to (or as a consequence of) Due to (or as a consequence of)

completion of cause of death?

1 Yes 2 No

2000

29d. Date signed (Month, Day, Year)

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Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

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Completed

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filed within 72 hours after

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nt of Health a If them 27 is nor other tra-

21215-0020

Baltimore, Maryland

DOROTHY

215-16-6594

10a. State

MARYLAND

11 Marital Status

10e. Street and Number

12

WILLIAM

Examine burial-tran Physician/Medical the 980 p should be Completed Be 24 hours after death. filled in by

The law requires that the death certificate be executed

Box 68760

P.O.

Records,

Division of Vital or Attending Physician:

completely To the To the To the

Certification: To

Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Part II. Other algorificant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco usa contributa to the cause of death? 1 Yaa 2 No 3 Probably 4 Winknown C.O. D.D. BREAST CARCINOMA 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29e. Certifier (Check only one)

this

After

DR. K.S. DHARMASENA 31. Date filed (Month, Day, Year) State JAN 2 8 2000

29b. Signature and title of certifie

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30. Nama and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's Signature

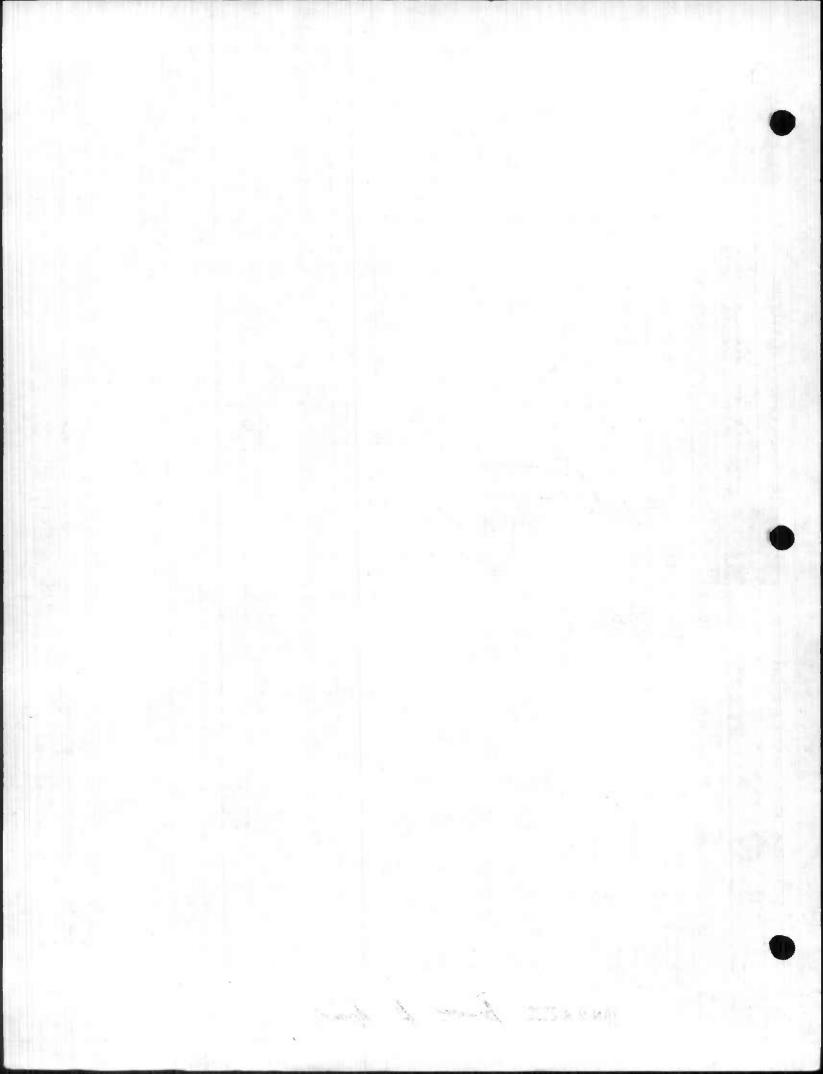
surgene, M.D.

710 CHURCH STREET, BROOKLYN PARK, MARYLAND

29c. License number

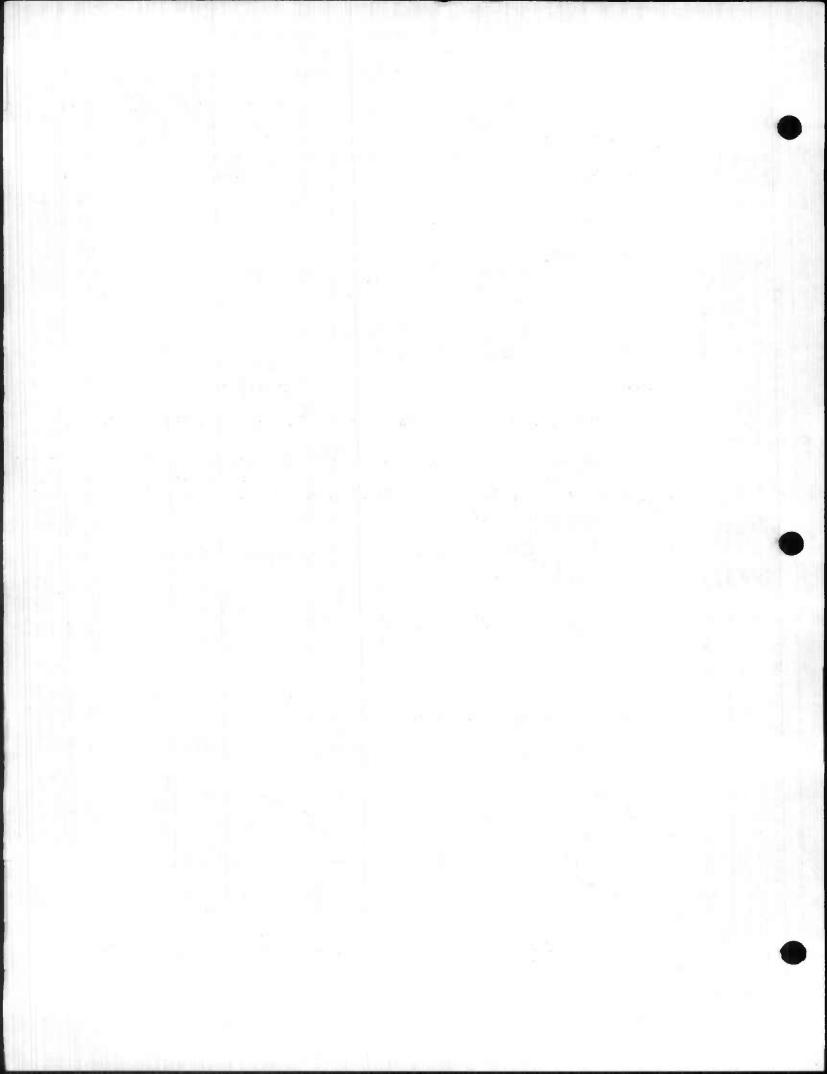
Registrar

Medical



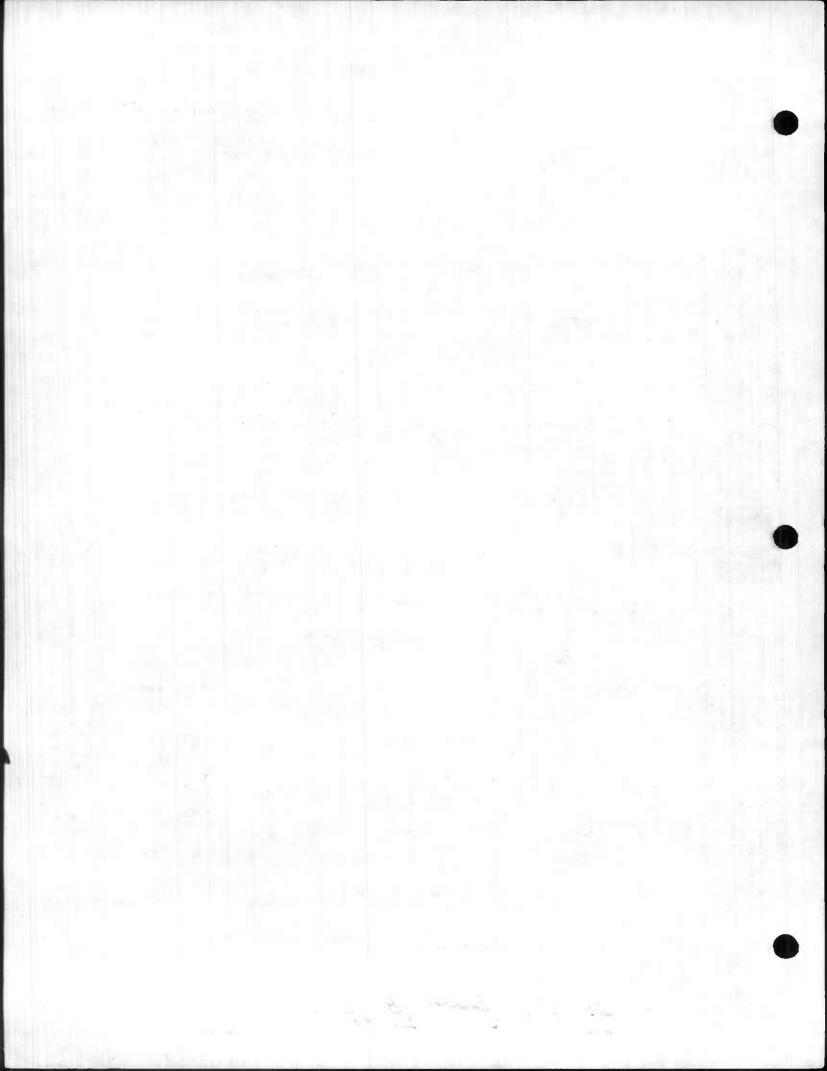
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| _ | | | State of Maryland / Department of F Certificate of | |
|-------------|--|------------------|---|---|
| | Physic | | Decedent's Name (First, Middle, Last) HELEN MASON | 2. Date of Death Month Day JANUARY 26, 2000 3. Time of Death 7:00pt |
| h | /Medi Examir | | | 4b. City, Town, or Location of Deeth 4c. County of Death |
| | | | FUTURECARE AT HOMEWOOD | BALTIMORE N/A |
| | Funerai Director | | 5. Social Security Number 219-30-4487 Usual Residence of Decedent 6. Sex 1 M 2 F 7. Age (In yrs. lest birthday) 79 Yrs. 1 Vinder 1 Year 79 Yrs. | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 12-26-20 9. Birthplace (State or Foreign Country) MD. |
| | anyland show dat | - | 10a. State 10b. County 10c. City, Town or Location | 10d. Inside City Limit |
| | the M | Director | MD. N/A BALTIMORE 10e. Street and Number 10f. Zip Code | 1 ☑ Yes 2 ☐ N |
| | with with | ā | | |
| | death | Funeral | 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of H | Hispanic Origin? (Specify Yes or No- 14. Raca - American Indian, |
| 070 | 72 hours after death with the Manyland natural, or items 23a or 28s-f show dital Examiner insit be notified at | by | 3 ☑ Widowed 4 □ Divorced Year or Dates: | an, Mexican, Puerto Rican, etc.) Specify: BLACK |
| 71215-0020 | C | Completed | 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occup (Give kind of work done life. DO NOT use retired | during most of working |
| | filed within Hygiene. other than " | Con | -12O- SALES CLERK | |
| \subseteq | id be fil lental H ked oth | To Be | 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Sumeme) LUCILLE SIMPSON |
| Mary | 2 8 8 | - | 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street | end Number or Rural Route Number, City or Town, Stete, Zip Code) AVE. BALTIMORE, MARYLAND 21217 |
| ນົ | s 1 and if Health Item 27 other tr | | 20a. Method of Disposition 20b. Placa of Disposition (Name of | Date 20c. Location - City or Town, Stete |
| Ĕ | Pages nent of } int: if ite | | Mail Burial 2 Cremetion 3 Chemoval from State | ETERANS 2-3-2000 OWINGS MILLS, MARYL |
| Dail | permit. Pages 1 and Department of Health Important: If Item 27 any injury or other to once. | | 21. Signature of Funeral Service Licenses 22. Name and Addre | ass of Facility VERNON R. BAILEY FUNERAL SERVIOR MONROE ST. BALTIMORE, MARYLAND 2121 |
| | Physician /Medical Examiner | her | 23a. Part1. Enter the disease, or complications that cause the death. Do not enter the mode of dyir shock, or heart failure. List only one cause on each ne. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence ot): | Onset and Death |
| ,00100 | deeth certificete be executed e ettending physician and of for use es the burial-transit | ledical Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last b. Due to (or as a consequence of): Due to (or as a consequenca of): | YM |
| Y 20 | death certifice ettending ph d for use es t | lan/M | d | |
| | or Attending Physician: The law requires that the interdeath. Nirector: After this certificate has been signed by the in by the funeral director, page 2 should be deteched in by the funeral director. | by Physician/M | Part II. Other significant conditions contributing to death but not resulting in the underlying cause give CVA (Hemonthy) with Shu | 23b. Did tobacco use contribute to the cause of deal 1 Yes 2 No 3 Probably |
| | | Completed b | Dementia With Shu | 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? |
| = | | Com | | 1 Yes € No 1 Yes 20 No |
| 101 | | Be | 25. Was case referred to medical examiner? Hospital: Oth | 26. Place of Death (Check only one) |
| 5 | | tion: To | 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28b. Time of Injury Wor | ry at 28d. Describe how injury occurred |
| | | Certification: | 3 Suicide 4 Homicide 6 Could not be determined 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street end Number or Rural Route Number, City or Town, State) |
| | To the Hospital or within 24 hours after To the Funeral Dir completely filled in | edical | 29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the tire (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my of and manner stated. | me, date end plece, and due to the cause(s) and manner as stated. opinion, death occurred at the time, date and placa, and due to the cause(s) |
| | To the within To the | Me | 29c. Licens | 29d. Date signed (Month, Dey, Year) |
| | ł. | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) | PATRICE AD PROPRIETE |
| | V) | | | |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dsv Year Month Physician Nascr avid Wagner 2000 January 18, 15:55 /Medical 4c. County of Death 4a Fscility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Hospita Heart Cumberland acred If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 6. Sex 1 M 2 □ F 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 170 Yrs. 203 30 4271 Usual Residence of Decedent February 5, 1929 Pennsylvania Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mentel Hygiens. Important: If Item 27 is marked other than "natural", or Items 23s or 28s-1 show eny injury or other traumatic avent, the Medical Example maint be northed pages. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Xyes 2 No sarrett Director Grantsville 10f. Zip Code 10s. Street and Number 10g. Citizen of What Country? 1.5.A. 21536 Funeral 12. Wss Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bieck, White, etc. 11 Marital Status Amed Foldes!
1 2 Yes 2 No
If Yes, Give
Year or Dates: | 950 - 1953 1 Never Married 2 Married altimore, Maryland 21215-0020 1□ Yes 2No by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Retail Florist Store lorist 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Margaret Harri Charles Louise 19b. Msiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Rd. , MD Nascr 879 E | 50 Grantsville 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stste 1 Burial 2 Cremation 4 Donation 5 Other (5 3 Removal from State 61ft Foundation 1119/00 5 Other (Specify) Anatomic 6 ift Foundation 22, Name and Address of Facility Avenue Laurel MD 20707 13948 Baltimore plications that caused the death. the mode of dying, such as cardiac or respiratory arrest Approximete Intervsl Between Onset and Death Physician /Medical diate Cause (Final disease or condition resulting in death) Examiner Physician/Medical Examiner To the Hospital or Attanding Physician: The law requires that the death certificate be associated within 24 hours after death.

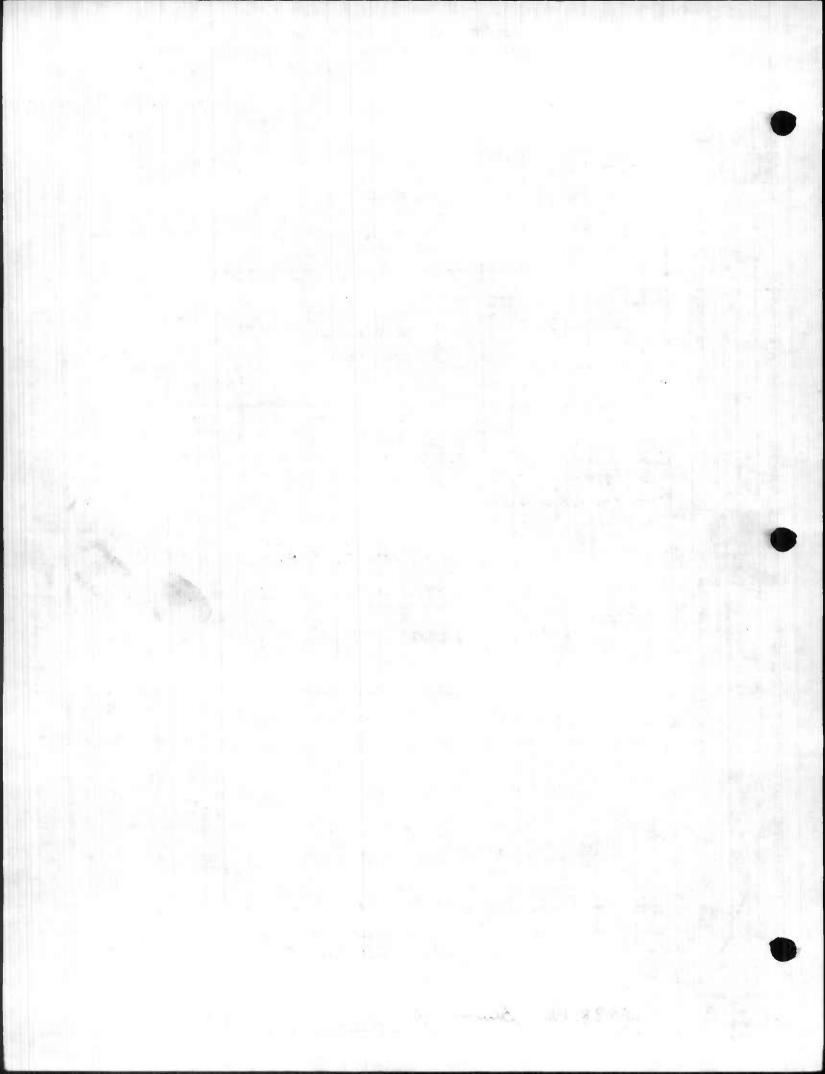
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the itmest director, page 2 should be deteched for use as the burlan-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or ss a consequence of): attanding physician for use as the burla P.O. Box 68760, Due to (or ss s consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. p 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed completion of cause of deeth? 1 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medicat examiner? 8 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 1 / Impatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27, Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. tnjury et Work? 5 Pending 1 Natural 1 Yes 2 No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29b. Signature end title of certifie 29c. License numbar 29d. Date signed (Month, Day, Year) January (cause of death (Item 23a) (Type, Print) Welik 902 umberland MD 21502 obert Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

| Harold B. Norvell Sale S | | | | | Cei | rtificate | of | Death | | | Reg. No. | JU | 6016 | | |
|--|--|--|---|-----------------------|--------------|----------------------------|----------------|-------------------|----------------------|---------------------------------------|----------------|---------------|---|--|--|
| ## County Obest 1215 Baker Avenue 4c. County of Death Market 1215 Baker Avenue 5. Social Security Number 6. Sex 12.44 20 F 7. App (fir yrs. last brithday) 10. Cety, Town or Location 10. Byth 10. County 10. Cety, Town or Location 10. Street and Number 10. Street and Number 10. Cety, Town or Location 10. Street and Number 10. Street Number 10. St | | Marold B. Norvell | | | | | | | | | | | | | |
| Security | | 4a Facility Name (If not institution, give street and number) 4b. City, Town, o | | | | | | | | Baltimore | | | | | |
| 10s. State 10s. Celly, Town or Location 10s. Celly, Town or Location 10s. Celly, Town or Location 10s. Streat and Number 11.215 Baker Avenue 1 | unerar | 382-03-7368 | 1☐ <u>₩</u> 2□ F | | | | | | | 8. Date of Bi (Month, Di 3/12/1 | 915" | | place (State or Fore stry) Souri | | |
| Elementary/Secondary (0-12) College (1-4or 5+) Stock Distributor Bethlehem Steel | unif, or items 23s or 28s-f show it Examiner must be notified at d by Funeral Director | 10a. State 10b. Cou | nty | | | | | | | | | 1 | 0d. Inside City Lin | | |
| Elementary/Secondary (0-12) College (1-4or 5+) Stock Distributor Bethlehem Steel | | | lvenue | | | | | 62 | | | - | | ntry? | | |
| Elementary/Secondary (0-12) College (1-4or 5+) Stock Distributor Bethlehem Steel | | 1 Never Married 2 N | Armed F lerried 1 1 3 Yes If Yes, G | orces? 2 No ive | | | | | gin? (Sp , Puerto | ecify Yes or No Rican, etc.) | | lack, Whita, | elc. | | |
| 23a. Part I. Enter the disease, or committee the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, the shock, or heart failure. List only one course on each line. 23a. Part I. Enter the disease, or committee the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, the provided in the shock, or heart failure. List only one course on each line. 25a. Part II. Enter the disease, or condition on each line. 25a. Part II. Other algorithment at lateral to the cause of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, the provided on the shock, or heart failure. List only one course on each line. 25a. Part II. Other algorithment at lateral to the cause of the death of the cause of th | ma Medical | (Specify only high | hest grade completed) | | (Give | kind of work DO NOT use | done retire | during most d) | of work | ing | | | | | |
| 23a. Part I. Enter the disease, or commission final caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, the proxist shock, or heart failure. List only one cause on each line. 23a. Part I. Enter the disease, or commission final caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, the proxist shock, or heart failure. List only one cause on each line. 25a. Part I. Enter the final disease or condition. 25a. Part I. Enter the final disease or condition. 25b. Due to (or as a consequence of): 25c. Due to (or as a consequence o | rked otheric avent. | | | 1 | | | | | | | | ame) | | | |
| 23a. Part 1. Enter the disease, or commission has been shock, or heart failure. List only one cause on each line. 23a. Part 1. Enter the disease, or commission has caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, talory one cause on each line. 25a. Part 1. Enter the disease, or commission has cardiac or respiratory arrest, talory one cause on each line. 25a. Part 1. Enter the disease, or commission has cardiac or respiratory arrest, talory one cause on each line. 25b. Due to (pr as a consequence of): 25c. Due to (or as e consequence of): 25c. Due to (| or treums | | | | | - | | | | | | | | | |
| 23a. Part I. Enter the disease, or committee the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, the shock, or heart failure. List only one course on each line. 23a. Part I. Enter the disease, or committee the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, the provided in the shock, or heart failure. List only one course on each line. 25a. Part II. Enter the disease, or condition on each line. 25a. Part II. Other algorithment at lateral to the cause of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, the provided on the shock, or heart failure. List only one course on each line. 25a. Part II. Other algorithment at lateral to the cause of the death of the cause of th | ant: If Nem lury or oth | 1 Burial 2 Cremetic | | State | Air M | emoria | or place | Garder | | | | | | | |
| Immediate Cause (Finel disease or condition resulting in death) Sequentially tist conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): | Departiment any injuries. | 21. Signature of Funeyal Service Licensee 22. Name and Address of Fecility Dippel Funeral Home Inc. 7110 Belair Road Baltimore, Maryland 21206 | | | | | | | | | | nc. 21206 | | | |
| d. Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. CORONARY ARTERY OISEASE 1 Yes 20 No 3 Probably of the cause of | miner right mansit Examiner | disease or condition resulting in death) Sequentially tist conditions, if any leading to immediate | a | Po | | | 35 | Car | is ce | 2 | | | Tyrs | | |
| Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. CORONARY ARTERY OISEASE 1 Yes 2 1 No 3 Probably | for use a | that initiated events resulting in death) Last Due to (or as e consequence of): | | | | | | | | | | | | | |
| 24a. Was an autopsy performed? 24b. Were autopsy performed? 24completion of death? | by the ached | CORON | ARY A | | | O/S 2 | se giv | en in Part I. | | | | | | | |
| | has been a ye 2 should mpleted | | | | | | | | _ | perf | ormed? | av co | ere autopsy finding allable prior to impletion of cause death? | | |
| 1 Yes 2 No | tor, per | 25. Was case referred to med | cal | | | | | 26. Place | of Deat | | | 1[| Yes 2 No | | |
| 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Whesidence 6 Other (Specify) | 10 P | 1 ☐ Yes 2 10 1No | 10 | | | 1111 | | 4LI NU | rsing Ho | | | | 'y) | | |
| 1 Natural 5 Pending (Month, Day Year) Injury Work? | the funer Cation: | 1 Natural 5 Per inve | ding (Mor stigation | nth, Day Year) | Injury | М | 10 | | No | 28d. Describe how injury occurred | | | | | |
| 28e. Plece of Injury - At home, larm, street, factory, office building, etc. (Specify) 28e. Plece of Injury - At home, larm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route In City or Town, State) | illed in by | 4 Homicide determined 286. Please of Injury - At nome, tarm, street, factory, office building, etc. (Specify) | | | | | | | | wn, State) | | | | | |
| 29a. Certifier (Check only one) | nplately nedica | (Check only 2 Medic one) | al Examiner: On the b and man | esis of examinatio | on and/or in | vestigation, in | my o | pinion, dea | n piace, | and due to the red et the time, | date and place | e, and due to | the cause(s) | | |
| X Euchara 4000 MDD41080 1/21/00 | X | 1 Cuch | ana s | food | N | OD | icens j/ | e number | | | 29d. Date sign | 7 OC | Day, Year) | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ARCHANA 5000 104, PWM TREE Rd. BUAIR Mo State 31. Date filed (Month, Day, Year) 32, Registrar's Signeture | | ARCHANA | 5007 | > 1 | 04, | Print) | y - | TR61 | = R | d. | But | HR | Md 21 | | |
| Registrar / JAN 2 8 2000 State | State | | | registrar's Signatu | 6 | bon | 1 | 4 | | | | | | | |



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienen Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month Effie Bell Norton 26,2000 January 11:40am 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Manor Care Ruxton Towson Baltimore 5. Sociel Sacurity Number If Under 1 Yaar If Undar 24 Hrs. 8. Deta of Birth (Month, Day, Year) July 23,1898 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foreign Country) Days Hours 1□ M 2 F 215-01-2686 Yrs 101 Maryland Usuai Rasidance of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Baltimore Towson 1□Yes 2ੴNo 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 7001 N. Charles Street 21204 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedant of Hispenic Origin? (Specify Yes or No-if Yas, specify Cuben, Mexican, Puerto Rican, atc.) 14. Rece - Amarican Indien, Black, White, etc. 1 Yas 2 No if Yas, Giva Yaar or Datas: 1 Never Marriad 2 ☐ Married 1 Yas 2 No Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grada complated) 16e. Decedent's Usuel Occupation (Give kind of work dona during most of working life. DO NOT usa ratired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Collega (1-4or 5+) Housewife Own Home 17. Fathar's Name (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Sumema) Maurice DeBeer Nellie Bond 19a. Informant's Neme/Ralationship (Type, Print) 19b. Malling Address (Straet and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Donna Bliss (Guardian) 915 Weatherbee Road, Towson, Maryland 21286 20b. Piace of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stete 1 Burial 2 □ Cramation 3 □ Ramoval from Stata 1/31/00 Baltimore, Maryland Loudon Park Cemetery 4 Donat 5 Other (Specify) 22. Nama and Addrass of Facility Witzke Funeral Homes, Inc. Perai Service Licensee 1630 Edmondson Avenue, Catonsville, MD 21228 the disaasa, or complications thet causad tha daath. Do not entar tha moda of dying, such es cardiec or respiretory errest, and feilura. List only one ceusa on aach lina. Im hadir te Causa (Final disaasa or condition rasulting in death) Stroke Days Dua to (or as a consequence of): Sequantially list conditions, if any, laading to immadiata causa. Entar Underlying Ceusa (Diseasa or injury that initiated evants rasulting in daeth) Last Dua to (or es a consequança of): Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings availabla prior to complation of causa of daath? 24a. Was an eutopsy 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case refarred to medical examinar? 26. Piece of Death (Check only ona) Hospitel: Other: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1 Inpatient 2 ER/Outpetient 3 DOA 28a. Data of Injury (Month, Dey Year) 27. Mannar of Death 28d. Dascribe how injury occurred 28b. Time of 28c. Injury at Work? Netural 5 Pending

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

þ

Completed

Funeral

Director

7 is marked other than "natural", or items 23s or 28s-f show treumstic event, the Medical Examiner invalided at

permit. Peges 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or ite any finlury or other traumatic event, the Medical Exam.

Baltimore, Maryland 21215-0020

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physician end the bunal-transit 98 950 signed by t been

Examiner

Physician/Medical

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Certification:

Medical

2 Accidant

3 Suicida

29a. Cartifiar

4 - Homicide

(Check only one)

certificate hes funeral c

the death certificate be executed Division of Vital Records, P.O. Box 68760, Mospital or Attending Physicien:
 24 hours effer death.
 Funeral Director: After this certific.

To the To the To the F

31. Deta filed (Month, Day, Yeer) State JAN 28 2000 Registrar

investigation

6 Could not be datarmined

29c. Licensa number D-12849

1 Certifying Phyaician: To the best of my knowledga, daath occurred at tha tima, data and piace, and dua to the cause(s) and manner as stated.

1 ☐ Yas 2 ☐ No

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, dete and piece, and due to the cause(s) end manner stated. 29d. Data signed (Month, Day, Year)

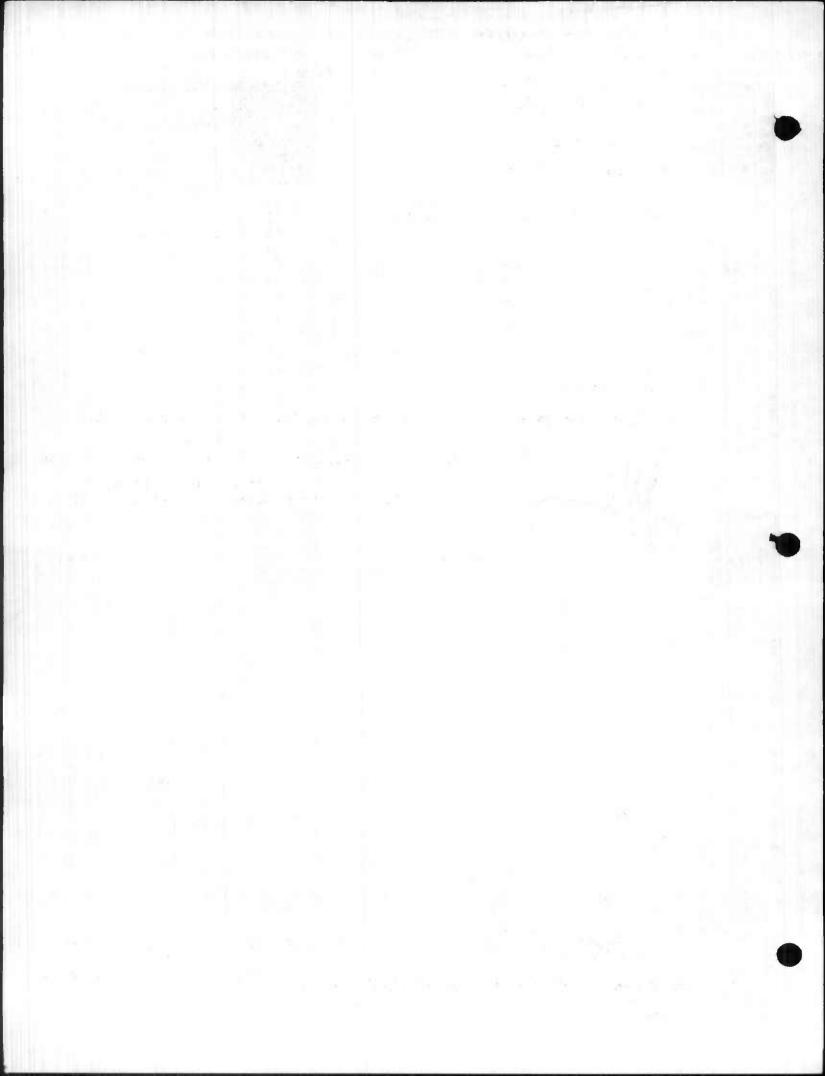
28f. Location (Street end Number or Rural Routa Number, City or Town, Stata)

30. Name and address of parson who completed causa of death (Itam 23a) (Type, Print)

OSLER Dr. TOWSON, Md. 21204 MD. 7600

32. Registrer's Signatura

28a. Placa of Injury - At homa, farm, streat, factory, office building, atc. (Specify)



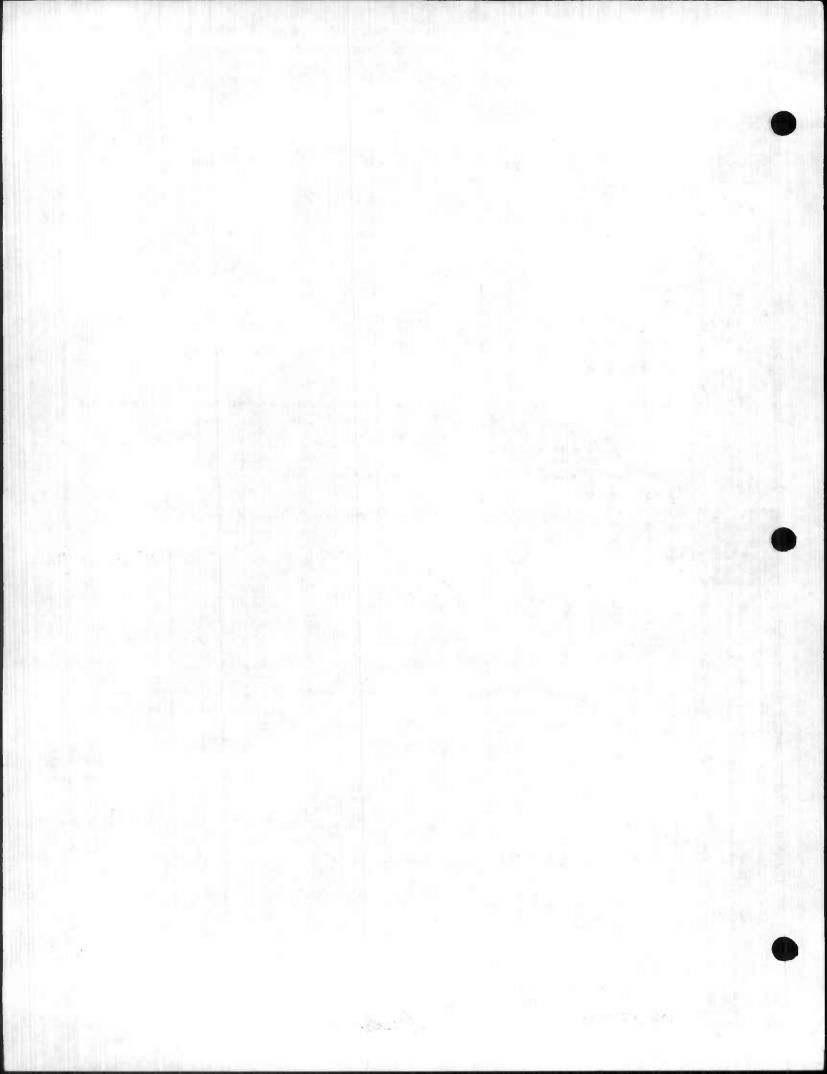
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene \(\) Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician EVELYN NewmAN 2:45 AM TAN 2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 7. Age (In yrs. last birthday) DUNTY GENERA Nowar Noward Columbia If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplece (State or Foreign Country) **Funeral** Months Days Hours 1□ M 20 F Director 86 November 14, 1913 New York 103-30-5920 Usual Residence of Decedent the Manyland 10d. Inside City Limits 10a State 10b County 10c. City, Town or Location r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21044 U.S.A. 6336 Cedar Lane # 169 Funeral deeth 14. Rece - American Indian, 11 Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Bleck, White, atc 1 ☐ Yes 2 N No filed within 72 hours after 1 Never Married 2 Merried Baltlmore, Maryland 21215-0020 1□ Yes 2 No Specify Specify White þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If fem 27 is marked other than "na eny injury or other traumatic avent seconds. Education Elementary/Secondary (0-12) College (1-4or 5+) Teacher/Assistant Principal 3 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 8 2 Philip Halprin Bertha "Unknown" 19e. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 9052 Bellwart Way Columbia, Maryland 21044 Mr. Michael Abrams Grandson 20b. Place of Disposition (Name of cemetery, crematory or other place) 20s. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremetion 3 Removel from State
4 Donation 5 Other (Specify) All County Cremation Services, Inc. 01/22/2000 Sykesville, Maryland 21. Signeture of Funeral Service Licensee 22. Name and Address of Facility Slack Funeral Home, P.A. M00535 3871 Old Columbia Pike Ellicott City, MD 21043 23a. Pert1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel disease or condition resulting in death) Examiner Examiner The law requires that the death certificate be executed **buriel-transit** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last pue P.O. Box 68760, attending physician for use as the burie Physician/Medical the Due to (or as e consequence of): MALFOYMANIOM GI Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? been signed by should be detac 1 Yea 2 No 3 Probably 4 Unknown Records, à 24b. Were autopsy findings evailable prior to completion of cause Be Completed 24a. Was an autopsy performed? of death? page 2 certificate 1 Yes 2 No 22 No Division of Vital To the Hospital or Attending Physicien: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director; 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 ☑Naturel 2 ☐ Accident 5 Pending investigation 1 Yes 2 No 3 Suicide 6 Could not be 281. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certified 29d. Dete signed (Month, Dey. Year) 29c License number address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar JAN 28 2000

DHMH 16 Ray 6/95



Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Tima of Death Dewey Wilson Puffenbarger JANUARY 25 2000 1:45 PM 4c. County of Death 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death GREATER BALTIMORE MEDICAL CENTER TOWSON BALTIMORE 5. Social Security Number 6. Sex 1 M 2 F If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
W. Virginia 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Months Days Hours Min. 81 577-20-8351 Usual Residence of Decedent 10c. City, Town or Location 10a Stata 10b County 10d. Insida City Limits 1 Yas 2 No Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4228 E. Joppa Road 21236 U.S.A. 14. Race - American Indian, Black, Whita, atc. 12. Was Decedent Ever in U.S. Apped Forces? 1∆ Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) 5+ Elementary/Secondary (0-12) Civil Engineer Corps of Engineers 18. Mother's Nama (First, Middle, Maiden Surnama) 17. Father's Name (First, Middle, Last) William H. Puffenbarger Ida M. Dixon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) Dewey W. Puffenbarger (son) 919 Shephard Ct., Bel Air, MD 21014 20b. Place of Disposition (Nama of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 NBuriat 2 Cremation 3 Removal Irom State 4 □ Donation 5 □ Other (Specify) Parkwood Cemetery 1/28/00 Baltimore, Maryland 21. Signature of Funerat Service Licensee 22. Nama and Address of Facility But a. Willer Schimunek Funeral Home, Inc. 9705 Belair Rd., Baltimore,

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. 21236 Approximata Intervat Between Onsat and Deeth Immediate Cause (Finat disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Wara sutopsy lindings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 Yes 1 Yas 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only ona) Hospital: DETNO Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 | Ves 1 [Inpatient 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Day Year) 27. Manpel of Death 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred

Physician /Medical Examiner

Department of Health important: if Ihem 27 is any injury or other tre

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should be filed within 72 hou and Mental Hygiene. I marked other than "nature urnetic event, the Medical E

Pages 1 and 2 should be nent of Health and Mental

Puffenbarge

Baltimore, Maryland 21215-0020

physician and the burial-transit 000 signed by the a d be detached f this

Physician/Medical Examiner þ Completed 8 Certification: To the funeral After

Box 68760. P.0. of Vital Records. or Attending Division To the Hospital or Attending within 24 hours effect death. To the Funeral Director: After completely filled in by the fun

DHMH 16 Rev 6/95

State Registrar

Medical

JAN 2 8 2000

1 Matural

2 ☐ Accident 3 ☐ Suicide

4 Homicide

(Check only one)

29a. Certifier

29b. Signature and title of certifier nale

5 Pending investigation

6 Could not be

Place of Injury - At homa, Iarm, street, fectory, office building, etc. (Specify)

29c. License number

1 Yes 2 No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated. 29d. Data signed (Month, Day, Year)

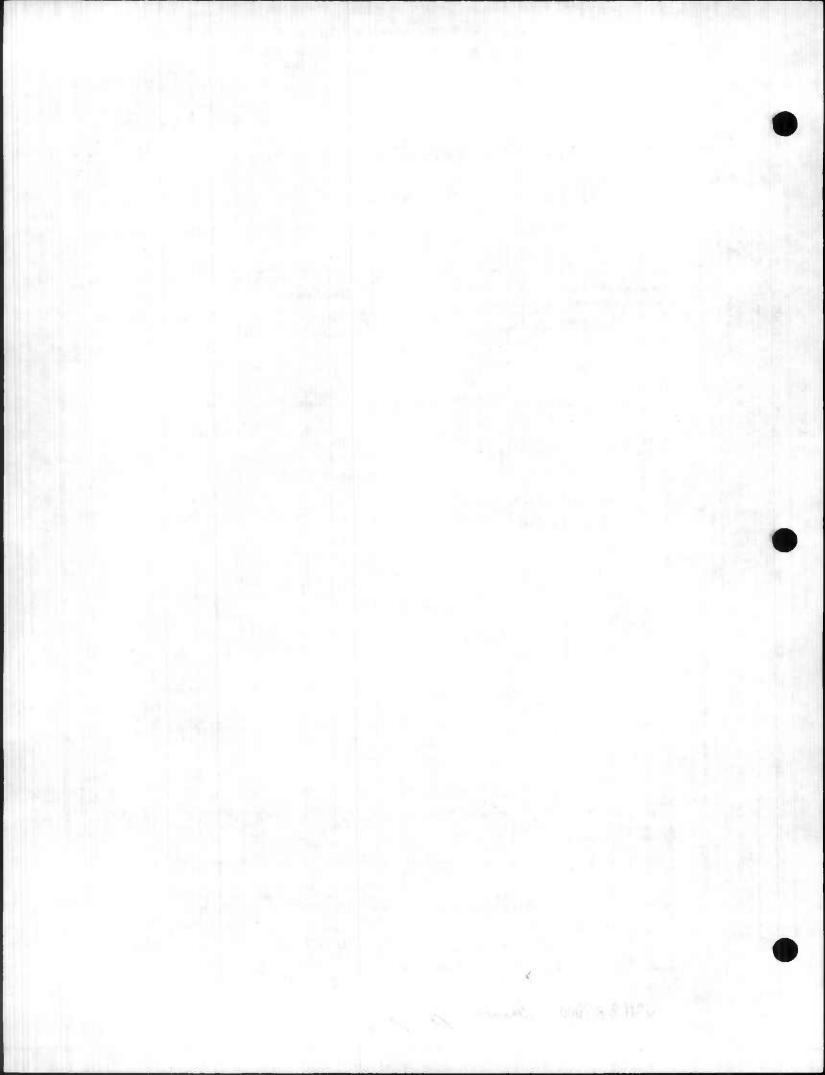
28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print) RICELY

6565 N. CHARLES ST.

TOWSON, MD 21204

32. Registrar's Signatura



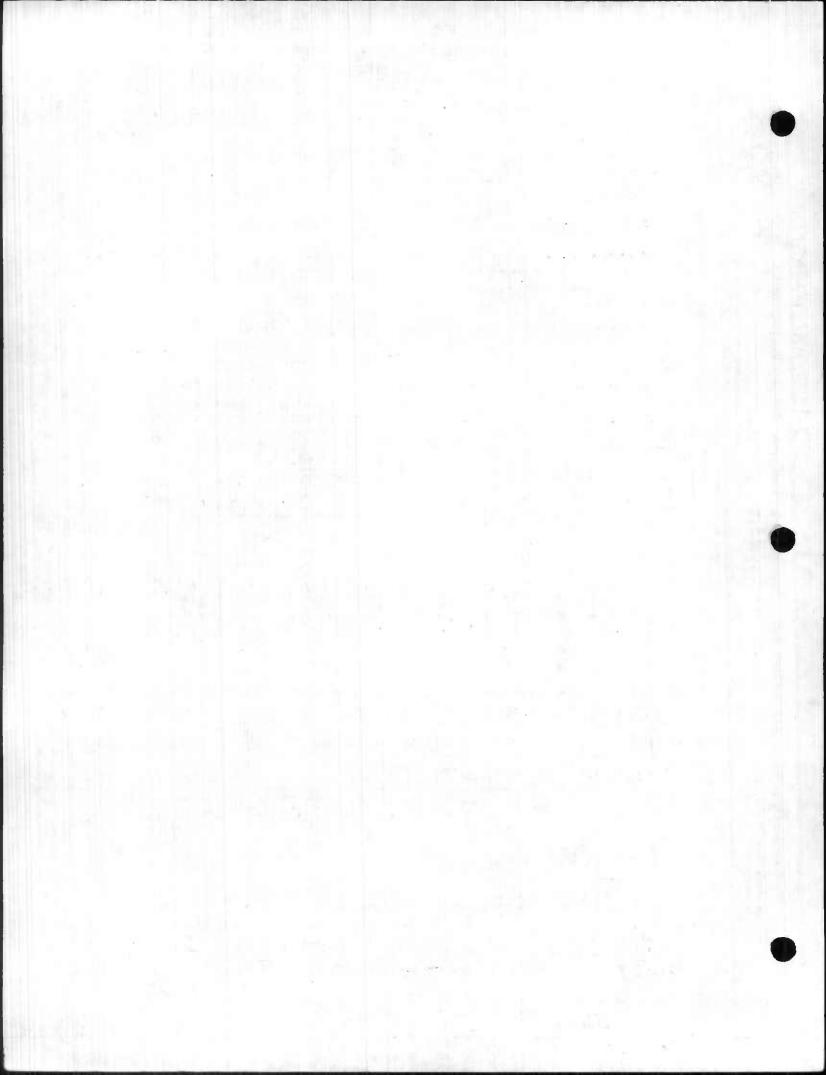
| Please Type or Print In Black Indelible Ink. | Assure All Coples Are Legible |
|--|-------------------------------|
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State of Maryland / Department of Health and Mental Hygiene

| | | Certificate of Death Reg. No. | | | | | | | | | | | | |
|-----------|---|--|---|---|-------------------------|----------------------|---|------------------|------------------------------|----------------------|--|-------------------------------------|---------------------------|---|
| | | | 1. Decedent's Nama (First, Middle, L. | est) | | | | | | | 2. Date of De Month | ath | Veer | 3. Tima ot Death |
| i. | Physicia /Medic | | | Lillia | n S. | Pl | ichta | | | | Januar | Day 22, 2 | Year | 10:35 PM |
| | Examin | 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of | | | | | | | | | | of Death | imore | |
| | Funeral Director | | 212-22-1980 | Sex 1□ M 2€ F | Aga (In yrs. 88 | last birthd Yrs | Months | r 1 Yaar Days | | 24 Hrs. Min. | 8. Data of Birt (Month, Da Sept. 6 | y, Year) | Coun | lace (State or Foreign itry) y Land |
| | death with the Maryland ms 23e or 28e-f show critical be notified at | ctor | Usual Residence of Decedent 10a. State 10b. County Maryland Ba | ltimore | 10c. Ci | ty, Town o | | Edger | mere | | | | 1 | 0d. Inside City Limits 1 ☐ Yes 2 ☒ No |
| | h with th | Funeral Director | 10e. Street and Number 7823 Denton Ave | . #5 | | | 10f. Zi | Code | 21219 | | | 10g. Citizen of V United | | - |
| 020 | within 72 hours after one. than "natural", or the | D. | 11. Maritat Status 1 Nevar Married 2 Married 3 Widowed 4 Divorced | 12. Was Deceder Armed Forces 1 Yas 25 If Yes, Give Yaar or Datas | i? ∄No | l,S. 1 | 3. Was Dece If Yes, spe 1 ☐ Yes | | | gin? (Sp , Puerto | ecify Yes or No Rican, etc.) | - 14. Rac Blac Specify | e - Americ ck, White, | |
| 0-61212 | | Completed | 15. Decedent's Education (Specify only highast grada comple Elamentary/Secondary (0-12) Colle 1 Ye | | ted) (ge (1-4or 5+) | | Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Nurse | | | | ing | 16b. Kind of Be Health Profes | Care | dustry |
| and | EIFE | Be Co | 17. Fathar's Name (First, Middle, Las |) | | | | | 18. Mothe | r's Nam | e (First, Middle, | Maiden Suman | na) | |
| <u>a</u> | | 0 | Thomas Joseph Fr | yer | | | | | | Vio: | la May A | Angel | | |
| , Mar | and 2 should saith and Mer n 27 is marks ser traumatic | | 19a. Informant's Name/Relationship Cecile G. Staffo | | ter) | | - | | | | | er, City or Town, Maryla | | Code) 21219 |
| aitimore, | Pages 1 ent of H mt: If iten ry or oth | | 20a. Method of Disposition 1 ⊠ Burial 2 ☐ Cremation 3 [4 ☐ Donation 5 ☐ Other (Special Content of the Content | | 0 | cemetery, | sposition (Na crematory or od Ceme | other pla | | 9/20 | Date 000 | 20c. Location - Baltin | | wn, State Maryland |
| Dail | permit. Pa Department important: eny injury | | 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 | | | | | | | | | | | |
| | Physician | | 23a. Part1. Enter the disease, or con ahock, or heart failure. List only | plications that cause on each | ed tha deat line. | h. Do not | | | | | | 4 | | Approximate Interval Between Onset and Death |
| ¥ | /Medical Examiner | | Immediate Cause (Final disease or condition resulting in death) | . Myo | | | | | VFAI | ec | MON | <i>l</i> . | | 27 DAYS |
| | nsit | miner | | · COR | 9 Ne | AR | 7 A | RI | ERY | | DISE | ASE | | OYFARS |
| 09/90 | | al Examin | | | | | | | | | | | SYEARS | |
| 20x 22 | E D E | an/Medical | | | | | | | | | 2 | LYEARS | | |
| 5 | requires that the death een signed by the atten hould be detached for u | by Physician/ | Part II. Other algnificant conditions HYPER C | contributing to death | | | | | ven in Part I | | | tobacco use co Yss 2 No | ntribute to | the cause of death? |
| coras, | w require been sig should b | oleted t | THROMA | | | | cA- | | | | 24a. Was perlo | an autopsy med? | av: | ere autopsy tindings allabla prior to mpletion of causa death? |
| VIII HE | n: The la ficate has or, page 2 | | CHRONIC 25. Was casa referred to medical | GAS71 | RIT | 15 | | | | | 10 | / | | Yes 2□ No |
| | s certi | 0 | examinar? | Hospital: | tient 2 | ER/Outpa | itient 3 D | OA Ot | hor: a | | h (Check only o | dence 6 Oth | er /Snecih | w) |
| 5 | hystcian: The law his certificate has bal director, page 2 s | | 27. Manner of Deeth 1 Natural 5 Pending 2 Accident investigation | 28a. Date of In (Month, E | | 28b. Tim Inju | | 28c. tnju Wo | | | | how injury occur | | |
| DIVISION | al or Attended in Director din by the | Certification: | 3 Suicide 6 Could not be detarmined 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number City or Town, State) | | | | | | | per or Rura | I Routa Number, | | | |
| | to the Hospital or vithin 24 hours after to the Funeral Dir completely filled in | edical | 29a. Certifier (Check only one) 1 Certifying Pl | nysician: To the bes miner: On the basis end manner: | of examina | wledge, detion and/o | eath occurred r investigation | at the ti | ime, date an opinion, dea | d place, th occur | and due to the red et the time, | cause(s) and madate end place, | anner as si and due to | tated. o the cause(s) |
| | To the To the Comp. | - | 29b. Signand whand title of contriber | B- ms | | | 29 | C. Licens | se number | 0 | | 29d. Date signe JANVAR | Month, | Day, Year) 2,2000 MORE |
| | 10 | | 30. Antho Dod golden At beisen who | countries of chine do | depth (the | 54110 | pe, Prign | RIT | CHIE | HC AN | GHWA D 2 | 45 BA | UTIN | MORE |
| N. | Stat | | 31. Date filed (Month, Day, Year) | 32. Regis | trar's Signa | ature | 6 | 1 | 1 | - 11 | , | | | - |

Registrar

DHMH 16 Ray 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month WILLIAM **PERDUE** 7:15 P.M. JAMMARY 26 2000 4a Fecility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death BAITIMORE Rosedale By H Under 24 Hrs. 8. Dete of Birth Dec 24 Year 922 SQUARE 8. Sex Hospilal 7. Age (In frs. last birthday) FRANKlin ENTER I Va 5. Social Security Number Birthplace (State or Foreign Country) Days Months 1√2 M 2□ F 236-20-6174 WestVirginia Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Baltimore Essex 1 Yes XXNo 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 516 Riverside Drive 21221 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Baca - American Indian 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Merried 2 Married 1 ☐ Yes 2 1 No Specify: White Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Electrician Crown Cork & Seal 8th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) unknown unknown 19a. intormant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) William H Perdue / son 9877 Bird River Road Baltimore Md. 21220 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State b Burial 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) 1/29/2000 Baltimore Md. Oak Lawn Cemetery 21. Signature of Funerel Service License 22. Name and Address of Facility Connelly Funeral Home of Essex 23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) FAILURE VEAR Due to (or as a consequence of) HEAR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence ot): of INFECTION week Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown beTes MelliTys 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Was an autopsy performed? **b**RillATION 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case reterred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpetient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) 27. Manner of Death 28b. Time of 28d. Describe how Injury occurred 28a. Date of Injury (Month, Day Year) 28c. tnjury at Work? 1 Natural 2 Accident 5 Pending 1 ∏ Yes 2 ∏ No investigation 6 Could not be determined 3 Suicide 28t. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Placa ot tnjury - At home, tarm, atreet, tactory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. I Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29a. Certifier

The law requires that the death certificate be axecuted Box 68760. P.O. Division of Vital Records. or Attending Physician:

Be Completed by Physician/Medical edical Certification: To this After within 24 hours after death. To the Funeral Director: A filled in by the Hospital

Physician

/Medical

Examiner

Director

Funeral

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Completed

Be

Funeral

Director

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Hygiene.

1 and 2 should be Health and Mental

Pages

Physician

/Medical

Examiner

Baltimore,

State Registrar

(Check only one)

29b. Signeture and title of certifier

29c. License number

29d. Date signed (Month, Dey, Year)

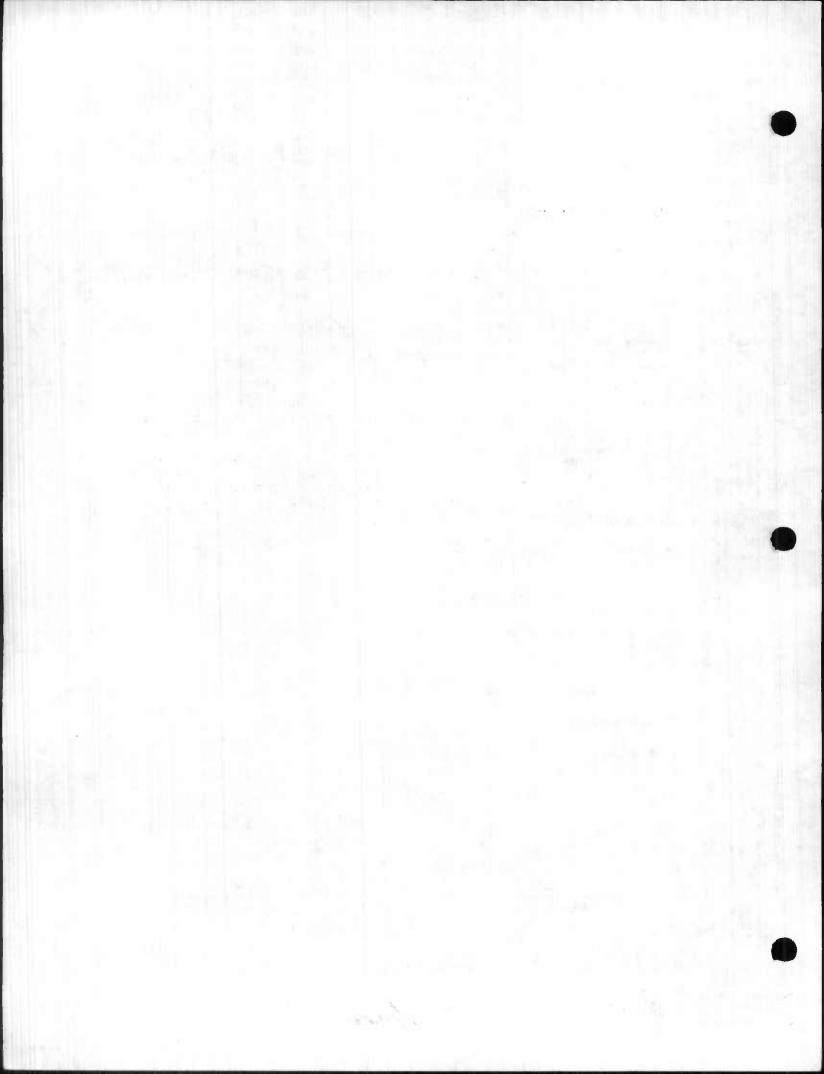
D53547

126/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FRANKlin Square DR. BAITIMORE, MARYLAND

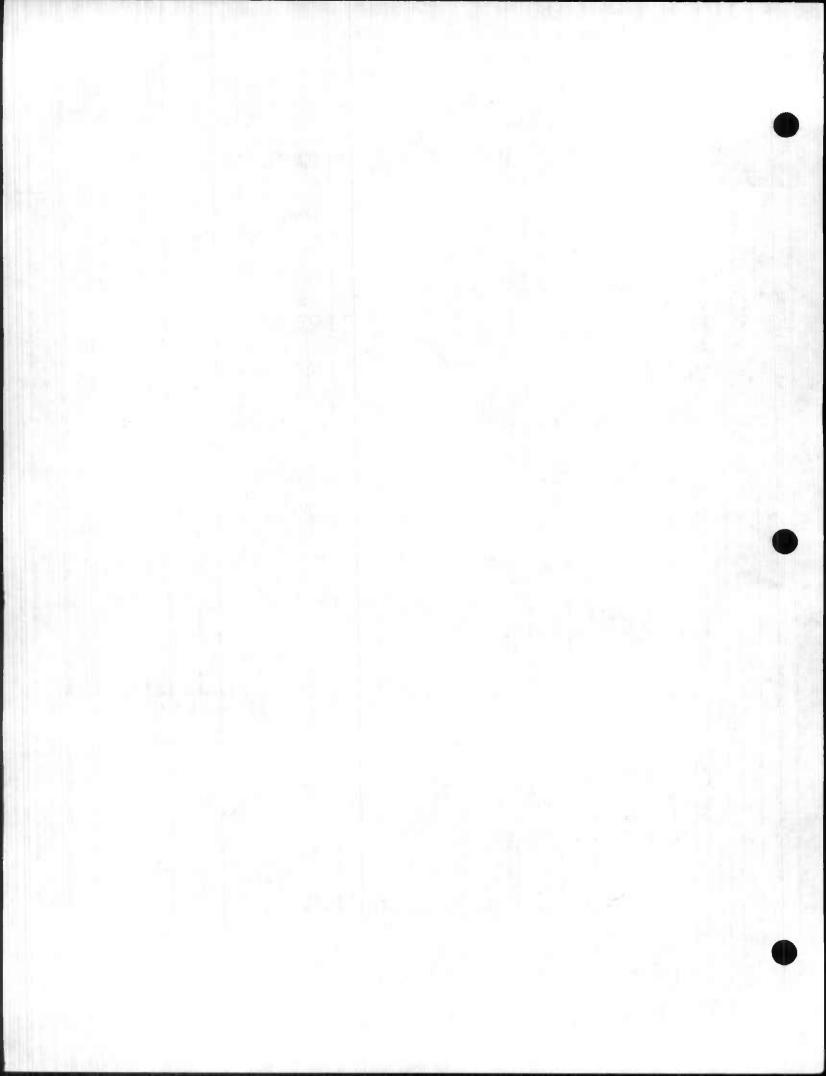
DR SANJAX JAGANNATH 31. Date tiled (Morth, Dey, Year) 32. Registr JAN 2 8 2000 Server 9000 32. Registrar's Signature



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 2 0

| | | | | Ce | rtificate of | Death | | Reg. No. | 0 12 2 7 0 | | | | | |
|--|---|---|--|--|---|--------------------------------------|---|---|--|--|--|--|--|--|
| | Physician | Decedent's Name (First, Middle, Las | ORAL | J P01 | LAN JR. | | 2. Date of De Month JAN | Dey | Year 7:30am | | | | | |
| | /Medical Examiner | 4e Facility Neme (If not institution, give | allie and a second | | | | or Location of Deat | h 4c. County | | | | | | |
| T T | Funeral Director | 5. Sociel Security Number 6. Se | | rs. last birthdey Yrs. | Months Deys | r If Undar 24 H | | rth sy, Year) | 9. Birthplace (State or Foreign Country) WestVirginia | | | | | |
| The state of the s | Maryland 4 show lad at for | Usual Residence of Decedent 10a. State 10b. County Md. Baltimo | | City, Town or L | | ddle Riv | | | 10d. Inside City Limits 1 ☐ Yes 2 【No | | | | | |
| | ar death with the Maryla herrs 23s or 25s-1 show ner must be notified at uneral Director | 10e. Street and Number 37 B Cedar Driv | 7e | | 10f. Zip Code | 21220 | | 10g. Citizen of V | | | | | | |
| 020 | Example Dy F | 11. Marital Status 1 Never Merried 2 Merried 3 Widowed ***Divorced | 12. Was Decedent Ever in Armed Forces? 1 | 1 U,S. 13. | Was Decedent of If Yas, specify Cu | Hispenic Origin? ban, Mexican, Pu | (Specify Yes or No erto Rican, atc.) | 14. Red Blad | ca - American Indien, ck, White, etc. V: White | | | | | |
| aryland 21215- should be flied within 72 od Mental Hygiene. marked other than "net urrette event, the Madig | Ta find at | 15. Decedent's Ed (Specify only highest grad Elementery/Secondery (0-12) | cation la completed) College (1-4or 5+) | (Give | edent's Usuel Occu e kind of work done DO NOT use retir | upetion e during most of t ed) | working | | usiness/Industry | | | | | |
| | Be start | 8th 17. Father's Neme (First, Middle, Last) Oral J Polar | Sr | Pa | inter | 18. Mother's P | | Beth Steel me (First, Middle, Meiden Surneme) | | | | | | |
| | 일목점점 다 | 19a. Informent's Neme/Relationship (7 | | 19b. Mail | ing Address (Stree | et end Number or | Lona Ma | y Kiest per, City or Town, | | | | | | |
| - | and 2 salft a saff a er tras | Oral J Polan 111 | | | Stillwat | er Road | Baltin | nore Md. | 21221 | | | | | |
| | Pages 1 nent of Hs int: If item ary or oth | 20a. Method of Disposition 12 Burial 2 Cramation 3 4 Donetion 5 Other (Specify, | Ramoval from Stete | cametery, cra | osition (Name of ametory or other pl ill Cemet | | Dete 28/2000 | | - City or Town, Stata more Md. | | | | | |
| Balt | Departit Departit Importa any inja | 21. Signeture of Funeral Service Licensee Connelly Funeral Home of Essex 300 Mace Ave. Baltimore Md. 21221 | | | | | | | | | | | | |
| | death certificate be executed e attending physician and od for use as the burial-transit sician/Medical Examiner | Immediete Cause (Final disease or condition resulting in deeth) Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in deeth) Last | С | o (or es a conse o (or es e conse o (or es e conse | equenca of): | re Pul | Monary | disea | sa | | | | | |
| | | Pert II. Other significant conditions co | ntributing to death but not | resulting in the | undariying causa ç | jiven in Pert I. | | tobacco use co | ontribute to the cause of death? | | | | | |
| Hecords, P | aw requires the second | | | | | | 24a. We | s en autopsy ormed? | 24b. Ware autopsy findings available prior to completion of cause of death? | | | | | |
| | The page | | | | | | 10 | Yes 200No | 1 ☐ Yes 2 ☐ No | | | | | |
| on or vital | Attending Physician: The releash. setor: Attenthis conflicate by the funeral director, page the funeral director. | 25. Wes case referred to medical examiner? 1 Yes 2 No 27. Menner of Deeth Natural 5 Pending 2 Accident investigation | Hospitel: 1 Inpatient 2 28e. Dete of Injury (Month, Dey Year) | ER/Outpatie | of 28c. Inj | ther: 4 Nursin | g Home NZ Res 28d. Describe | | | | | | | |
| ā I | | 3 Suicide 6 Could not be 4 Homicide determined | 28e. Pleca of Injury - A building, etc. (Spe | t home, tarm, s | treet, tactory, office | 9 | | (Street end Num. own, Stete) | ber or Rurel Route Number, | | | | | |
| | Hospi 24 hour Funer tely fill | | sician: To the best of my iner: On the basis of examend manner steted. | | | | | | | | | | | |
| | To the comple | 29b. Signeture and title of certifier | w M. | D - | 29c. Lice | 3541 | | 29d. Date signe | 8 0 0 | | | | | |
| | 7 | 30. Name and address of person who to NACHUM PFE | | tem 23a) (Type | 6918 R | idge Ro | 1. Balti | more, | MD 21237 | | | | | |
| | State | 31. Data filed (Month, Dey, Year) | 32. Registrer's Signature | gneture | / . | 0 | | | | | | | | |



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene $\mathbb U$ Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month 6:10 pm Virgie Parsons 18 2000 January 4b. City, Town, or Location of Death 4e Fecility Neme (If not Institution, give street and number) 4c. County of Death Anne Arundel Arnold Chesapeake Future Care 5. Social Security Number If Under 1 Yeer 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Days 1 ☐ M 2 € F Months Hours 92 235-10-5438 Yrs. Aug. 31, 1907 West Virginia Usual Residence of Deceden 10a State 10b. County Anne Arundel 10c. City, Town or Location Arnold 10d. Inside City Limits 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21012 USA 305 College Parkway 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 20 No If Yes, Give Year or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indien. 11. Maritel Status Bieck, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grede completed) Elementery/Secondary (0-12) College (1-4or 5+) AACO. Public Schools Cafeteria Cook 4 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Fred Griffie Lulu C. Long 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informant's Name/Reletionship (Type, Print) 1642 Westchester Court, Annapolis, MD 21401 Faye B. Maisel - Daughter 20e. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Jan.21 Baltimore, MD Metro Crematory 2000 21. Signature of Funeral Service Licensee 22. Name end Address of Fecility Hardesty Funeral Home, P.A. utta 12 Ridgely Avenue, Annapolis, Maryland 21401 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in deeth) CYNECOLOGIC 3 MONTHS Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Wes an eutopsy performed? 1 Yes 1 TYes 2 No 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Physician /Medical **Examiner**

Physician

/Medical

Examiner

Director

Funeral

by

Completed

Funeral

Director

Examiner The lew requires that the deeth certificate be executed physician end s the burial-transit attending for use as ed by the a signed b been si il director, page 2 s Hospital or Attending Physician: 24 hours efter deeth. Funeral Director: After this certification by the funeral director.

P.O. Box 68760.

Division of Vital Records,

Physician/Medical þ Completed Be Certification: To

Medical

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Deeth

1 Naturel 5 Pending 2 ☐ Accident 3 Suicide 4 Homicide

investigation 6 Could not be determined 28a. Dete of injury (Month, Day Yeer)

28e. Piaca of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

28c. Injury at Work?

1 Yes 2 No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Phyalclar: To the best of my knowledge, deeth occurred at tha time, date and place, and due to the cause(s) and menner as stated.

| Medical Examinar: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signeture and title of certifier

29a. Certifier

29c. License number 30

29d. Date signed (Month. Day, Year) 30

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

600 RIDGELY Scott EDEN

31. Date filed (Montfi, Day, Year) 2 8 2000

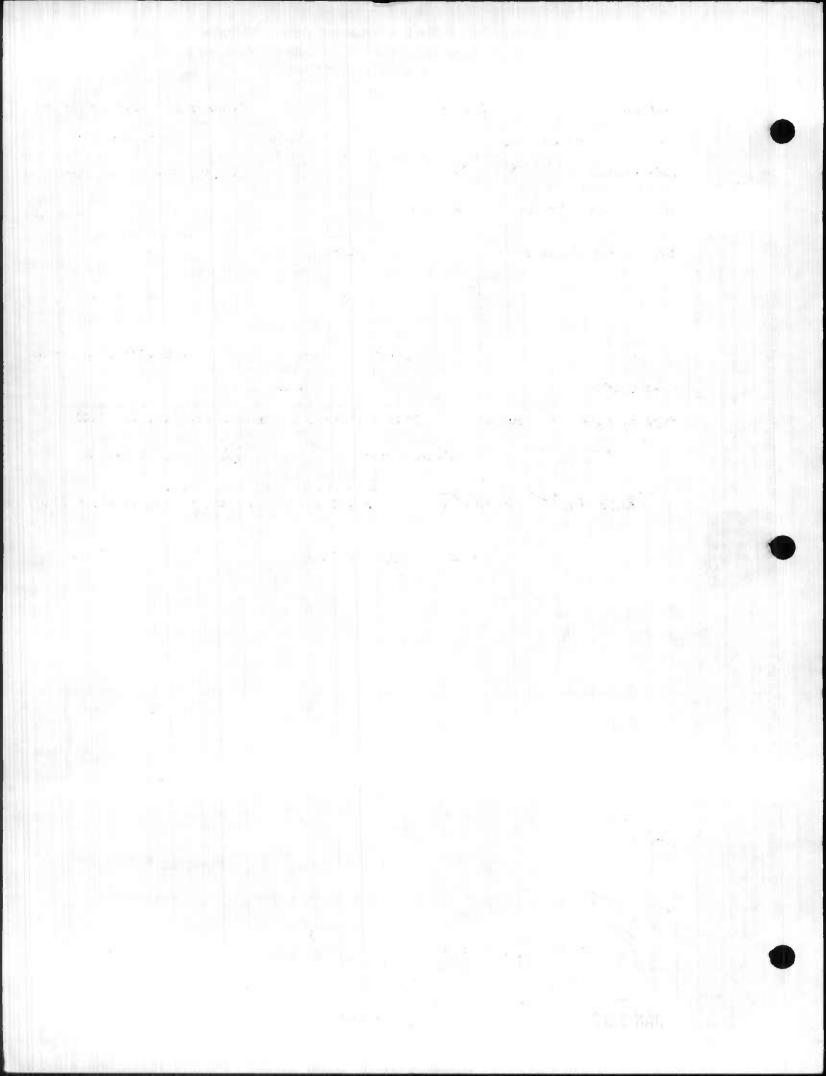
32. Registrar's Signature

AVE, ANNAPOLIS, MD 2140

State Registrar

DHMH 16 Rev 6/95

To the Hospital or within 24 hours aft To the Funeral Di completely filled in



Physician

/Medical

Examiner

Directo

Funeral

by

Funeral

Director

7 is marked other than "natural", or flems 23a or 28a-f show traumatic avent, the Medical Examinar must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental hygiene. Important: if them 27 is marked other recognitive or other trainers.

Physician /Medical

Examiner

physician and the burial-transit

signed by the

death.

after death Diractor:

Examiner

Physician/Medical

by

Completed

2

of Vital Division

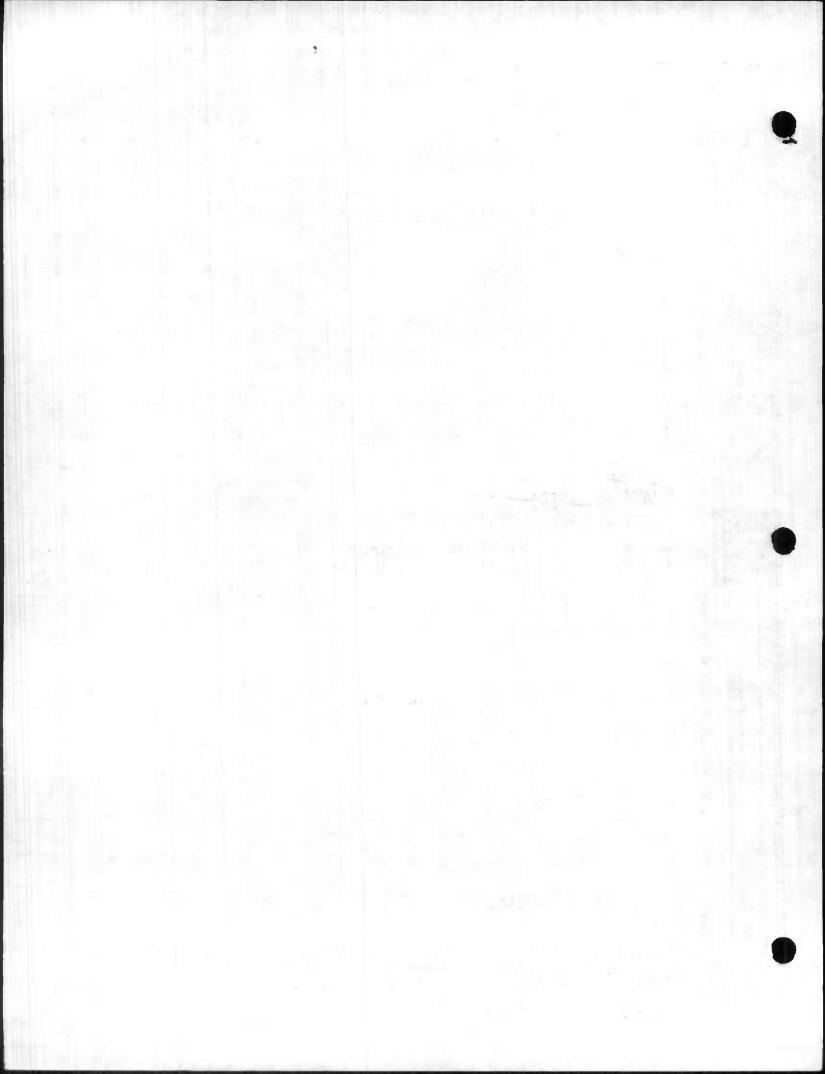
To the Hospital or Attan within 24 hours after dea To the Funeral Diractor completely filled in by th Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29e. Certifier Medical (Check only one) 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 053823 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) Henore St Bellinine Mg 21230 Ish MA Souls Thristopher 1147 31. Date filed (Month, Day, Year) 32. Registrer's Signature JAN 2 8 2000 Registrar DHMH 16 Rev 6/95 **ORIGINAL**

Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene amend item 7 perfh G779 1/28/00 yg Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Day **Physician** John W. Penn, Jr. 24, 2000 4c. County of Death JANUARY /Medical 2000 4:25 AM 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Saint Joseph Medical Center Towson Baltimore If Under 1 Yeer | If Under 24 Hrs. 8. Date of Birth Month, Day, Year, Aug. 15, 1911 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 180 M 20 F 89 88 Yrs. Months Days Hours Min. Maryrand 214-40-4476 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 X No Director Maryland Baltimore Baltimore 28a-f 8 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 6 mant b United States 4648 Darleigh Road 21236 Funeral 14. Rece - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White þ 3 ☑ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working tife. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Baltimore City Hygiens. Elementary/Secondary (0-12) College (1-4or 5+) Battallion Chief Fire Department 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fit ment of Health and Mental H lant; If Nem 27 is marked off Jury or other traumatic even Be John W. Penn, Sr. Frances "E. 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, MD 21236 7 Raylon Drive Apt. J Mrs. Evelyn Bandell / Sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stata 1 Ø Burial 2 ☐ Cremation 3 ☐ Removel from State Department of Important: If any Injury or 1/28/2000 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery 21. Signature of Furnital Service Licensee Timothy Harman 22. Name and Address of Facility Leonard J. Ruck, Inc. Funeral Home 5305 Harford Road Baltimore, MD 21214 23a. Part1. Enter the domains, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart to ure. List only one cause on each line. Approximate Intervel Between Onset and Death Physician Immediete Cause (Final disease or condition resulting in death) BILATERAL PNEUMONIA /Medical 10 DAYS Examiner Due to (or as a consequence of): Physician/Medical Examiner hysician and the burial-transit The law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of): Box 68760. that initiated events resulting in death) Last Due to (or as a consequence of): USB BS Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. CHRONIC OBSTRUCTIVE PULMONARY DISEASE P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed by CONGESTIVE HEART FAILURE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 2 1 Yes 2 No Certificate 1 ☐ Yes 2 No Physician: 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation or Attending 1 Netural 1 Yes 2 No within 24 hours after death, To the Funeral Director: A 2 Accident the 8 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) à 4 ☐ Homicide 2 pelli Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the best of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29e. Certifie completely (Check only one) \$ 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 mella mo D 41410 24 009. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOGINDER P. MEHTA, M.D., 7601 OSLER DRIVE, TOWSON, MARYLAND 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 2 8 2000 Registrar Darks



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 2082

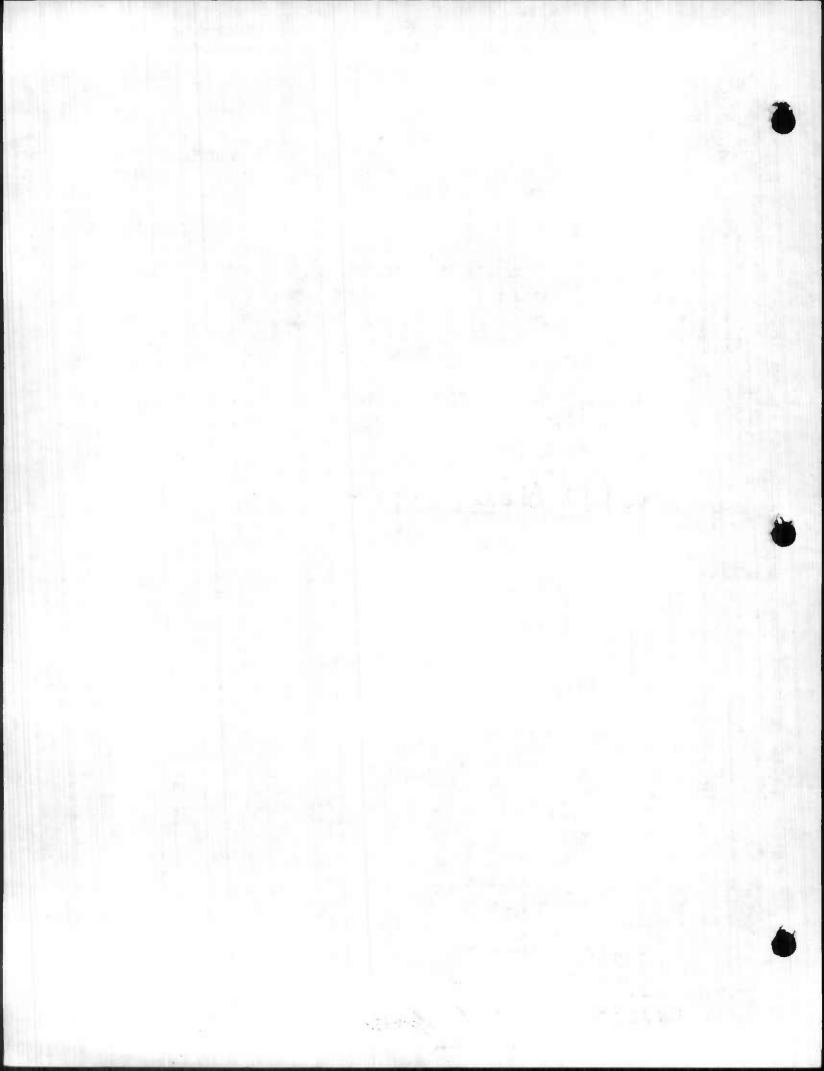
Certificate of Death

Reg. No.

| | | | | - | Cer | tificate of | Death | | Reg. No. | | | | | |
|--|--|--|---|----------------------------------|--|------------------------------------|--|---|------------------------------------|---------------------------------|--|--|--|--|
| | | it's Name (First, Middle | , Last) | | | | | 2. Date of De | ath | Year | 3. Tima of Death | | | |
| Physician Medica | | Loui | se A. | Pou1 | in | | | January | Day 25, 20 | | 1:15 AM | | | |
| Examine | de Espillar | | | | | | | Location of Deat | | | 1310 7111 | | | |
| 4 | A | nne Arundel | Medical (| Center | Hospit | al | Annapo | | | ne Ar | rundel | | | |
| Funeral Director | 048-1 | 6-4005 | 6. Sex 1 M 2 F 7. | Age (In yrs. le | Yrs. | Months Days | | 8. Date of Bir (Month, Da July 6. | | 9. Birthp Coun Mair | lace (Stete or Foreig try) 10 | | | |
| 2 8- | 10a. State | 10b. County | | 10c. City | , Town or Loc | cation | | | | 1 | 0d. Inside City Limits | | | |
| ta-f sh da-f sh diffed a | Maryl | | rundel | | | Annapol | is | | | | 1 ☐ Yes 2/CXNo | | | |
| th with the Ma 23a or 28a-f s wet be notified | | and Number O Bellerive | e Dr. | | | 10f. Zip Code 21 | 401 | | 10g. Citizen of What Country? | | | | | |
| 5-0020 72 hours after death v natural, or herms 234 disal Examiner must | 3 □X\Wid | 11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 Xidowed 4 Divorced 12. Was D Armed 1 Yes, | | | | Ves Decedent of Yes, specify Cu | Hispanic Origin? (S ban, Mexican, Puerl Specify: | pecify Yes or No o Rican, etc.) | Blac | e - Americ k, White, Whit | etc. | | | |
| Maryland 21215-0020 d2 should be filed within 72 hours at th and Mantal Hygiene. T is marked other than "natural", or traumatic event, the Medical Exam To Be Commissed by it | Elemente | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired) | | | | 16b. Kind of Bu | iianu | facturing | | | |
| M. Hand | | Name (First, Middle, L | ast) | 4 | | Quality Inspector | | | Meiden Sumer | | | | | |
| d be milit if it is a second | 11 | illie | | Daigle | | | Alexi | | | aigle | | | | |
| hould Man marks marks | | eant's Name/Relationsh | | 3.4 | 19b Mailin | n Address (Stree | et and Number or Re | | | | | | | |
| Magaga Ma | | ine M. Pasi | | tor) | | 1 | ub Circle | | | | | | | |
| | | d of Disposition | era (Daugi | 20b. Pl | aca of Dispos | ition (Name of | | Date | 20c. Location - | | | | | |
| dall(Imore, semit. Pages 1 a separtment of Heal mportant: If Item in Injury or other thick. | | rial 2 D Cremation nation 5 Other (Sp | | 210 | | matory or other pl | | 1/27/00 | Baltimo | ro N | larvland | | | |
| I defend | | in of Funeral Service L | | 1100 | | Name end Add | | 1/2//00 | Darcino | C . I | aryrana | | | |
| D MAN AND AND AND AND AND AND AND AND AND A | b | Stallings Funeral Home PA | | | | | | | | | | | | |
| | 23a, Part1 | Enter the disease, or | (DIDO | 1 | 31 | 11 Moun | tain Rd. | Pasadena | , Md. 2 | 1122 | Annoulmete | | | |
| | shook | , or heart failure. List o | nly one cause on each | h line |) Do not ente | ir the mode of dy | ring, such as cardia | or respiratory a | rrest, | 1 | Approximate Interval Between Onset and Death | | | |
| Physician / /Medical | Immediate | Cause (Final | Const | | 7 | | | | | 1 | | | | |
| Examiner | disease or resulting in | condition | aCerb | oral va | scular | Accide | nt | | | 12 | Days | | | |
| | | Dua to (or as a consequence of): | | | | | | | | | | | | |
| bed is | | | b | | | | | | | ì | | | | |
| executed in and riel-transit | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | | | | | | | | | | | | | |
| certificate be executed rding physician and use as the burlal-transit | cause. En Cause (Dis | cause. (Disease or Injury | | | | | | | | | | | | |
| ficate be ever physician is the buria | that initiete resulting in | death) Last | | Due to (or as e consequence of): | | | | | | | | | | |
| 1 0 0 | | | | | | | | | | | | | | |
| death cert a strength of for usa | 5 | | | | | | | | | - 1 | | | | |
| es that the death ce igned by the attendii be detached for use by Physician/ | Part II. Other | Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given | | | | | iven in Part I. | 23b. Did tobacco usa contribute to the cause of | | | 2.1 | | | |
| that the ded by detac | | | | | | | | 10 | Yaa 2□ No | 3 Pro | bably 4) Unknow | | | |
| The law requires the cate has been signe, page 2 should be d | | | | | | | | 24a Waa | an autopsy | 24h W | ere autopsy findings | | | |
| v require been si should l | 5 | | | | | | | | ormed? | av | ailable prior to mpletion of cause | | | |
| has b | | | | | | | | | | of | death? | | | |
| The L | 3 | | | | | | | 10 | Yes 2 No | 1[|]Yes 2□No | | | |
| Physician: The Physician: The rithis cartificate and director, page Co. | 25. Wes ca axamin | se referred to medical | Libraria-trans | | | | | ath (Check only | one) | | | | | |
| this of the T. | 1 Ye | | Hospital: 1 🖾 Inp | | R/Outpatient | 3LI DOA | | | denca 6 □Oth | | y) | | | |
| Affect funera | 27. Manner | | 28a. Date of I (Month, | Day Year) | 28b. Time of Injury | 28c. Inj | | 28d. Describe | how injury occur | red | | | | |
| Attending r death. Actor: Afte by the fune | 2 Ac | ident investig | | | | M 1[| Yes 2□No | | | | | | | |
| LIVISION OF VIKEL RECORDS, tall or Attending Physician: The law requires the state death. In Director: After this certificate has been signed in by the funeral director, page 2 should be Certification: To Be Completed by | 3 □ Su 4 □ Ho | dotomi | and 266. Place of | Injury - At hor, etc. (Specify, | ne, farm, stre | et, factory, office | à | 281. Location (City or To | Street end Numb wn, State) | er or Rura | Il Route Number, | | | |
| | | | | | | | | | | | | | | |
| To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral Medical Certification: | 29e. Certifi (Check | only 2 Medical E | Physician: To the be xaminer: On the basis | s of examineti | dedge, deeth on and/or inv | occurred at the estigation, in my | time, date end place opinion, death occu | , and due to the irred at the time, | cause(s) and ma dete end plece, | anner as s and due to | tated. o the cause(s) | | | |
| Withir To the comp | | ure and title of gertifier | 0// | | , | 29c. Licer | nse number | | 29d. Date signe | d (Month, | Dey, Year) | | | |
| | • | DITI | Min | n | | D2 | 24804 | | January | 27. | 2000 | | | |
| | 30. Name 6 | nd address of parson w | no completed cause | of death (Item | 23a) (Type 5 | | | | o arradi y | -/, | 2000 | | | |
| 9. | | ert T. Pet | | | | | apolis, M | 14 2440 | 1 | | | | | |
| AT AT A STATE OF | | d (Month: Dev. Year) | | istrar's Signati | | TVC. AIII | iapo115, N | 140 | L | | | | | |

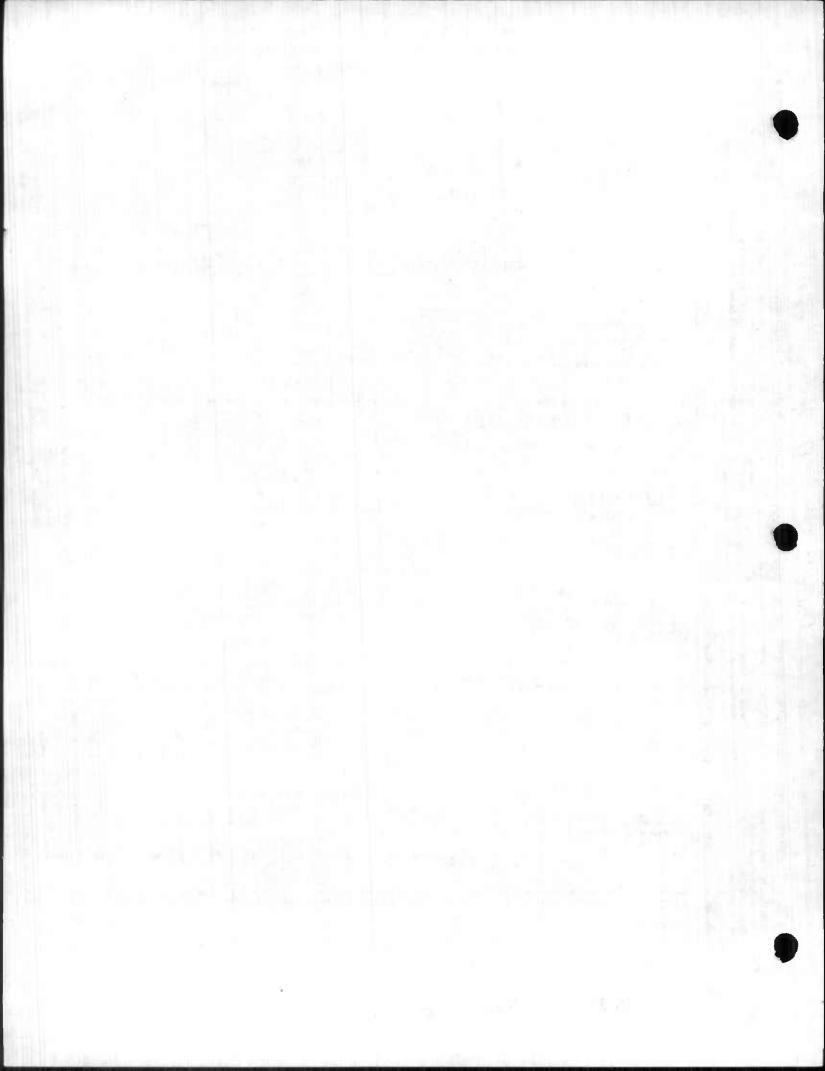
DHMH 16 Rav 6/95

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

| | | Certific | ate of Death | Reg. No. | 02083 | | | | | |
|---|---|---|--|--|---|--|--|--|--|--|
| Division | Decedent's Name (First, Middle, Last) | 1 | | 2. Date of Death Month Day | 3. Time of Death | | | | | |
| Physician /Medical | C'Leo RIC | hards | | JAN 27 2 | 2000 6:30 PM. | | | | | |
| Examiner | 4s Facility Name (If not institution, give street and number | | 4b. City, Town, or Los | | | | | | | |
| MAN TO THE | HOSPICE OF BALT | im ore-Gila | real Tows | SON BY | 4ctimore | | | | | |
| Funeral Director | 5. Social Security Number 6. Sex 1 M 2 F 7. A | ge (In yrs. last birthday) If Un 5 8 Yrs. Month | der 1 Year If Under 24 Hrs. hs Days Hours Min. | 8. Date of Birth (Month, Day, Year) NOU 18, 1941 | 9. Birthplaca (State or Foreign Country) MARY LAND. | | | | | |
| 2 . | Usual Residence of Decedent 10s. State 10b. County | 10. Ch. T | | | | | | | | |
| vith the Marylar t or 28a-f ahow be notified at | 10e. State 10b. County M.D. BALTIMORE | 10c. City, Town or Location | BALK | | 10d. Inside City Limits 1 ☐ Yes 2 No | | | | | |
| § 2.4 D | 1909 Dineen Dr | | Zip Code 2 1 Z 2 Z | 10g. Citizen of N | What Country? | | | | | |
| ozo ozo marter ario or he marter by Fur | 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Deceden Armed Forces 1 Yes, 2 If Yes, Give Year or Dates: | No 1□ Yes | cedent of Hispanic Origin? (Spe pecify Cuban, Mexican, Puerto F s 20 No Specify: | The state of the s | ce - American Indian, ck, White, etc. | | | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or | (54) life. DO NO | work done during most of workin Tuse retired) | Bo | usiness/Industry | | | | | |
| d 2121 Illed within Hygiene. And the Hygiene. And the Hygiene. And the Hygiene. | 12 th | A 558 | ombly wor | RKET FAC | TORY | | | | | |
| O EITEL O | 17. Father's Neme (First, Middle, Last) WILLIAM Shewb | ridge | 18. Mother's Name MARY | (First, Middle, Maiden Suman BARRET | | | | | | |
| Marylan sand 2 should be saith and Mariai no 27 is marked of the traumatic avo To Be | 19a. Informant's Neme/Relationship (Type, Print) DNALD RICHARDS (hv. | SBAND 1909 | Since And Number or Rural | Route Number, City or Town, | 111 - 1 | | | | | |
| Ore 1 then we off | 20a. Method of Disposition 1 ☐ Burial 2 € Cremation 3 ☐ Removel from State | 20b. Place of Disposition (I cemetery, crematory of | Name of or other place) | 3- 70 | - City or Town, Stele | | | | | |
| Baltim Baltim pemir. Pag Department Important: I | 4 Donetion 5 Other (Specify) 21. Signeture of Funeral Service Licensee | | ematory in and Address of Fecility nelly. Fune | 4 ./ | of Oundall | | | | | |
| 2 | Gulhowy C. Cor | melly 7110 | Sollers to | | teo. and. 21222 | | | | | |
| 3 | 23a. Pert1. Enter the disease or complications that cause shock, or heart tellure. Lat only one cause on each | od the death. Do not enter the mine. | node of dying, such as cardiac or | r respiratory arrest, | Approximate Interval Between Onset and Death | | | | | |
| Physician /Medical Examiner | Immediate Cause (Finel disease or condition resulting in deeth) a. | ing cano | er | | 1 Year | | | | | |
| 9 | | Due to (dr as a consequence of | of): | | | | | | | |
| 0, o, assected fiel-transit Examiner | Sequentially list conditions, | Due to (or as a consequence of | of): | | | | | | | |
| 60, be assected tolen and burial-transit | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or Injury | | | | | | | | | |
| 68760, egy physician as the buria | that initiated events resulting in death) Last Due to (or as a consequence of): | | | | | | | | | |
| Box ath certification of the control | d | | | | | | | | | |
| B. Bett death death death | Part II. Other significant conditions contributing to death | but not reculting in the underbrin | a cause given in Part I | 23h Did tohacco usa co | entribute to the cause of death? | | | | | |
| ds, P.O. Box ires that the death cei signed by the attendir d be detached for use d by PhysicianA | Fait it. Other eignineans continues continuently to death | out not resulting in the underlysh | g cause given in ran i. | 1 Yes 2□ No | 3 Probably 4 Unknown | | | | | |
| Division of Vital Records, P.O. Box 68760 or Attending Physician: The law requires that the death certificate be after death. After this certificate has been signed by the attending physicial in by the funeral director, page 2 should be detached for use as the bur entification: To Be Completed by Physician/Medical | | | | 24a. Wes an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause | | | | | |
| Rec | | | | 1 Yes 2 No | completion of cause of death? | | | | | |
| /Ital | 25. Was case reterred to medical | | 26. Place of Death | / | 10100 2010 | | | | | |
| of V hysician his certification of To E | examiner? 1 Yes 2 No Hospital: 1 Inpati | ient 2 ER/Outpatient 3 | Othor | ne 5 Residence 6 Noth | ver (Specify) HOSPICE | | | | | |
| g Ph g Ph first | 27. Manner of Death 1 Natural 5 Pending (Month, D | | | 8d. Describe how injury occur | тед | | | | | |
| atio | 2 Accident Investigation | M | 1 Yes 2 No | | | | | | | |
| DIVIS | 3 ☐ Suicide 6 ☐ Could not be determined 28e. Pleca of to building, e | jury - At home, farm, street, fact c. (Specify) | tory, office 2 | 18f. Location (Street and Numb City or Town, State) | per or Rural Route Number, | | | | | |
| Division of Vital Re To the Hospital or Attanding Physician: The Is within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page Medical Certification: To Be Com | 29e. Certifier (Check only one) Certifying Physician: To the best of Medical Examiner: On the basis of and menner st | of examinetion and/or investigati | ed et the tima, date and place, a ion, in my opinion, deeth occurre | and due to the cause(s) and mand et the time, date and place, | anner as stated. and due to the cause(s) | | | | | |
| To the somp | 29b. Signature and little of certifies | | 29c. License number | | od (Month, Day, Year) | | | | | |
| | Il. Bushing Kill | y, und | 125205 | Janua | my 28, 2000 | | | | | |
| 0 | 30. Name and address of person who completed cause of | death (Item 23a) (Type, Print) | D25205 St. Baltin | nore, md | 21204 | | | | | |
| State | 10. | rer's Signeture | , | | | | | | | |
| Panistrar | ALLIE O U COOL INTERPRETA | 14 | 4 | | | | | | | |



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Tima of Death Year Month 11700041 2000 OSAM 4e Facility Name (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death ltimore YOU If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country)

Maryland 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) Days 1□ M 20 F 216-61-2931 Usual Residence of Decedent Yrs. 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No MONIL in 10e. Street and Number 10f. Zip Code 10c. Citizen of What Country? 1/2 12. Wes Decedent Ever in U,S Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indien, Black, White, etc. 11. Meritel Stetus 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: 1 Never Merried 2 Merried 1□ Yes 2⊠ No Specify: Specify: White 3 ☑Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 19a. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) # 401 FBERSX Md 21093 1 imonium Jan 29 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removel from State Dulancy Valley Mem. Galdens! 2000 | 1 months 17 4 Donetion 5 □Other (Specify) 21. Signature of Funeral Service Licenses 23e. Pert1: Enter the disease, or complications that caused the death. Do not enter the mode of dying such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. 2/234 Approximete Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) eumonia Due to (or as e consequence of) Eyears S Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or as a consequence of) Due to (or es a consequence of): Pert II. Other algoriticant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Wera autopsy findings available prior to 24a. Wes an autopsy performed? completion of cause of death? 2 1100 1 Yes 2 No 1 Yes 25. Wes case referred to medical 26. Place of Deeth (Check only one) exeminer Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Menger of Death 28e. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Netural 5 Pending Investigation 1 Yes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29d. Date signed (Month, Day, Year) 26

P.O. Box 68760. Records,

The law requires that the death certificate be executed Division of Vital or Attanding Physician: n 24 hours after death.

Ne Funeral Director: Al plately filled in by the fu death. Hospital To the Hosp within 24 hor To the Fune completely fi

Physician

/Medical

Examiner

Funeral

Director

Herne 23s or 28s-f show

permit. Pages 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Important: If Itam 27 is merked other than "natural", or her any injury or other traumatic event

Physician

/Medical

Examiner

physician and s tha burial-transit

for usa as

ed by the a

sate has been signed page 2 should be de

certificate

this

After

Examiner

Physician/Medical

Aq

Be Completed

Certification: To

Medical

2 Accident

3 Suicide 4 Homicide

(Check only one)

29b. Signeture and fittle of certifier

29e. Certifier

Saitlmore, Maryland 21215-0020

Director

Funeral

Ag

Completed

Be 2

the Maryland

DHMH 16 Ray 6/95

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FRANCIS Willemann

31. Dete filed (Month, Day, Year) 32. Registrar's Signature JAN 2 8 2000

6 Could not be determined

28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and menner steted.

29c. License number



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

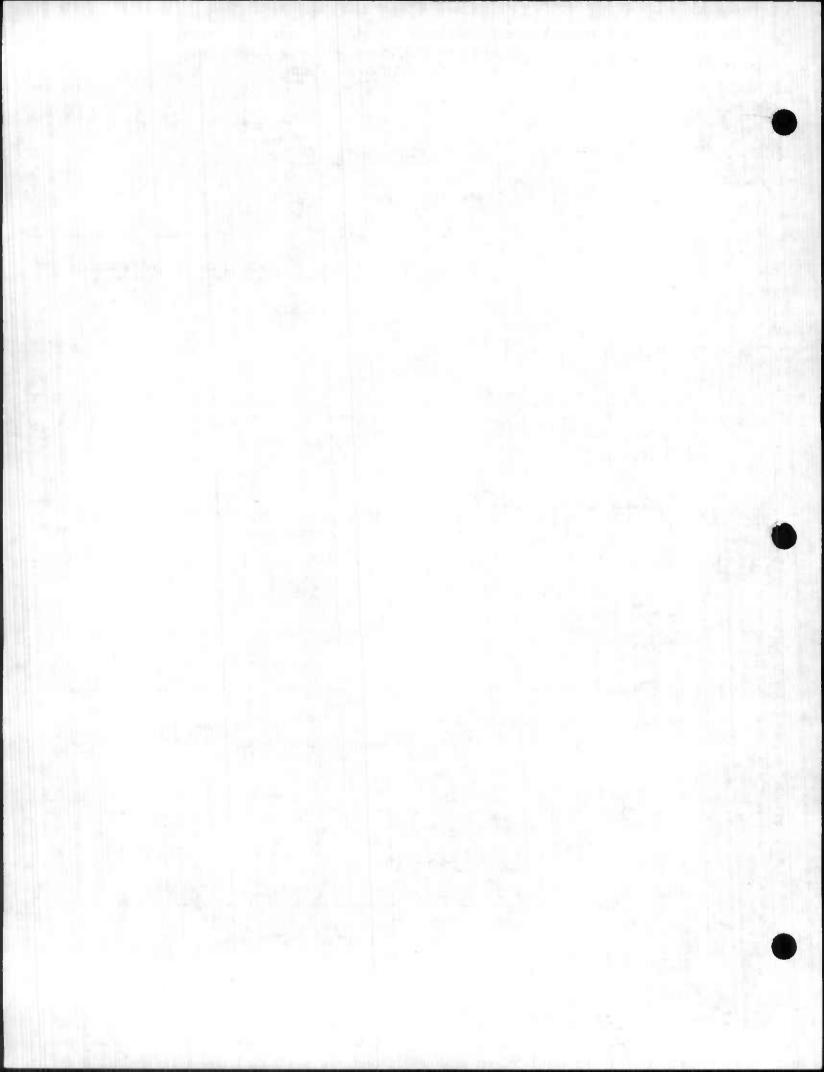
| state of Maryland / | Department | of Health and | Mental Hygiene |
|---------------------|------------|---------------|----------------|
| | | 4.50 | |

amend item 5 per fh G780 2/3/00 yg Certificate of Death 1. Decedent's Nama (First, Middle, Last) 3. Time of Death 2. Date of Death Month **Physician** Robinson Eppie January 2000 02:11 P.M. -√Medical 4b. City. Town, or Location of Death 4a Facility Name (If not institution, giva street and number) 4c. County of Death Examiner 314 East 28th Street Baltimore N/A If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 4770 6. Sex Birthplace (Stata or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1₽M 2□F Days 63 213-36-1770 Vrs MD Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits traumetic event, the Medical Examiner must be notified at MD NA Baltimore Yes 2 No Director 280-11 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene.
Important: If Hem 27 is marked other then any Injury or other traumer. USA 21218 314 East 28th Street 234 Funeral Was Decedant Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Raca - American Indian. Black, White, atc. Nas 2 No If Yes, Give Year or Datas: Nevar Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Construction worker Construction Co. 9th Grade 18. Mother's Nama (First, Middle, Maidan Sumama) 17. Father's Name (First, Middle, Last) Watkins Rosetta Robinson Eppie 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21218 19a. Informant's Name/Relationship (Type, Print) 429 Ilchester Street Baltimore, Maryland Carolyn Nicks 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stata MD 20a. Method of Disposition 1 DeBuriel 2 Cremation 3 Removal from State Garrison Forest VA Cem. 02-02-2000 Owings Mill 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee -22. Name and Address of Facility Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue uin plications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, one cause on each line. 23a. Part1. Enter the disease, or con nock, or heart failura. List only Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in deeth) Atherescleratic Cardiovasiular disease Examiner Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequenca of). Box 68760, Due to (or as a consequence of): P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown alcoholism þ Division of Vitai Records, 24a. Was an autopsy performed? 24b. Were autopsy findings svailable prior to completion of cause of death? eral Director: After this certificate has been si filled in by the funeral director, page 2 should I Be Completed 12 Yas 2 No 12 Yes 2 No Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 1 Yes 2 No 27. Manner of Death Medical Certification: 28b. Time of 28d. Describe how injury occurred Injury at Work? 5 Pending investigation 1 Yes 2 No death. 2 Accident 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) or A after 4 Homicide To the Hospital o within 24 hours af To the Funeral Di 29a. Cartifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and plece, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified O.C.M.E. January 18, 2000 MP 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Radentz 111 Penn Street, Baltimore, Maryland 21201 phen 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 16 Rev 6/95

ORIGINAL



Please Type or Print in Black Indelibie ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene (Certificate of Death 2. Data of Death 1. Decedent's Nama (First, Middla, Last) 3. Time of Death Alonzo Everett Reynolds January 25,2000 7:10 PM 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Harford Memorial Hospital Havre de Grace Harford If Under 1 Year | If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 02/13/1914 5. Social Security Number 9. Birthpiaca (Stata or Foreign Country) New York 7. Age (In yrs. last birthday) Days Months Hours 712-18-0148 t⊠M 2□F 85 Yrs. Usual Residence of Decedent 10a. Stata 10b. County t Oc. City, Town or Location 10d. Inside City Limits MD Harford Havre de Grace 1 ☐ Yas 2 € No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 1024 Chesapeake Drive 21078 U.S.A. t 4. Race - American Indian, Black, Whita, atc. t2. Was Decedent Ever in U,S. Armed Forces? t3. Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yas, specify Cuban, Mexican, Puarto Rican, atc.) 1 Yes 2 No If Yes, Giva Year or Dates: t Never Married 2 Married Specify: White t ☐ Yas 2 No Specify: 3 ☑ Widowed 4 ☐ Divorced t6a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) t5. Decedent's Education (Specify only highest grade completed) t6b. Kind of Business/Industry Elementary/Secondary (0-12) College (t-4or 5+) Budget Analyst Government 17. Father's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maiden Sumame) Alonzo Everett Reynolds Sr. Laura Fox 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Robert Reynolds/Son 1024 Chesapeake Dr. Apt 3D Havre de Grace MD. 21078 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Slate Balto./Wash. Crematory t ☐ Burial 2 ② Cremation 3 ☐ Removal from Stata 1/29/00 Laurel, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Nama and Addrass of Facility Dippel Funeral Home Inc 7110 Belair Road Baltimore, Maryland 21206 colors that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and cause on each line. 23a. Part1. Entar the disease, or comshock, or heart feilura. List only Approximate Interval Between Onset and Death Immediata Cause (Final RIGHT LUNG 10 DAYS diseasa or condition resulting in death) Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequenca of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 10 Yea 2 No 3 Probably 4 Unknown SEVERE CHRONIC OBSTRUCTIVE LUNG 24b. Wera autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? DISEASE 1 Yes 2 No 1 ☐ Yas 2 ☐ No 25. Was case referred to medical 26. Placa of Death (Check only one) Hospitel: t Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Residence 6 Othar (Specify) 1 Yes 2 No 27. Manner of Death 28c. Injury at Work? 28d. Describe how Injury occurred 28a. Data of Injury (Month, Day Year) 28b. Tima of 5 Pending invastigation t ANetural t ☐ Yas 2 ☐ No 2 ☐ Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 29a. Certifier (Check only one)

Box 68760, Attending Physicien: al or Atternate death.

funeral director, page 2 should be de

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or forms 23e or 28e-f show the Medical Examiner must be notified at

filed within 72 hours after

I Hygiene.

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if item 27 is marked othe eny Injury or other traumests.

Physician /Medical

Examiner

Physician/Medical

Be Completed by

Certification: To

21215-0020

Maryland

Baitimore,

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Time of Dach

Everett

eyno 165, 74 10,120

Funeral Director

Completed by

a. Division of Vital Records, Hospital To the Hosp within 24 ho To the Fune completely fi

DHMH 16 Rav 6/95

24 hours

State Registrar

31. Data filed (Month, Day, Year)

JAN 28 2000

Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

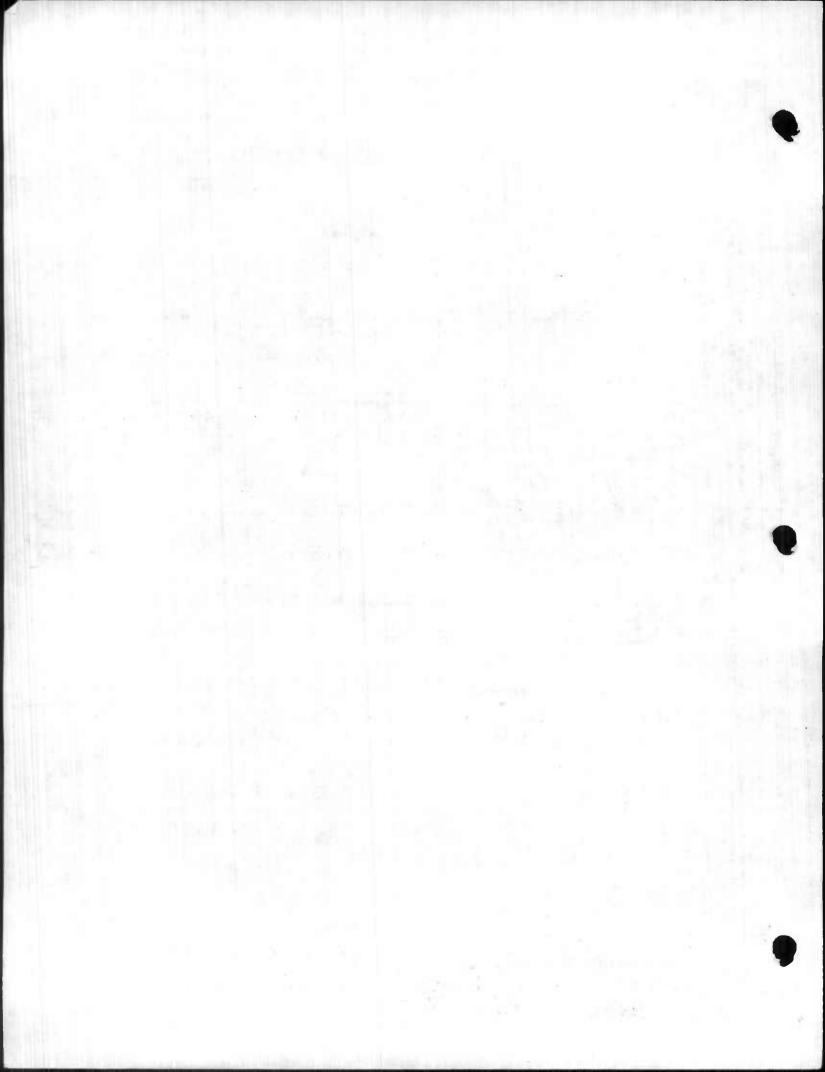
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29d. Data signed (Month, Day, Year) 29c. License number

01-26-00

cause of death (ttem 23a) (Type, Print)

622 S. UNION AVE, HAVRE DE GRACE, MD 21078. SURESH DHANTANI 32. Registrar's Signatura

ORIGINAL

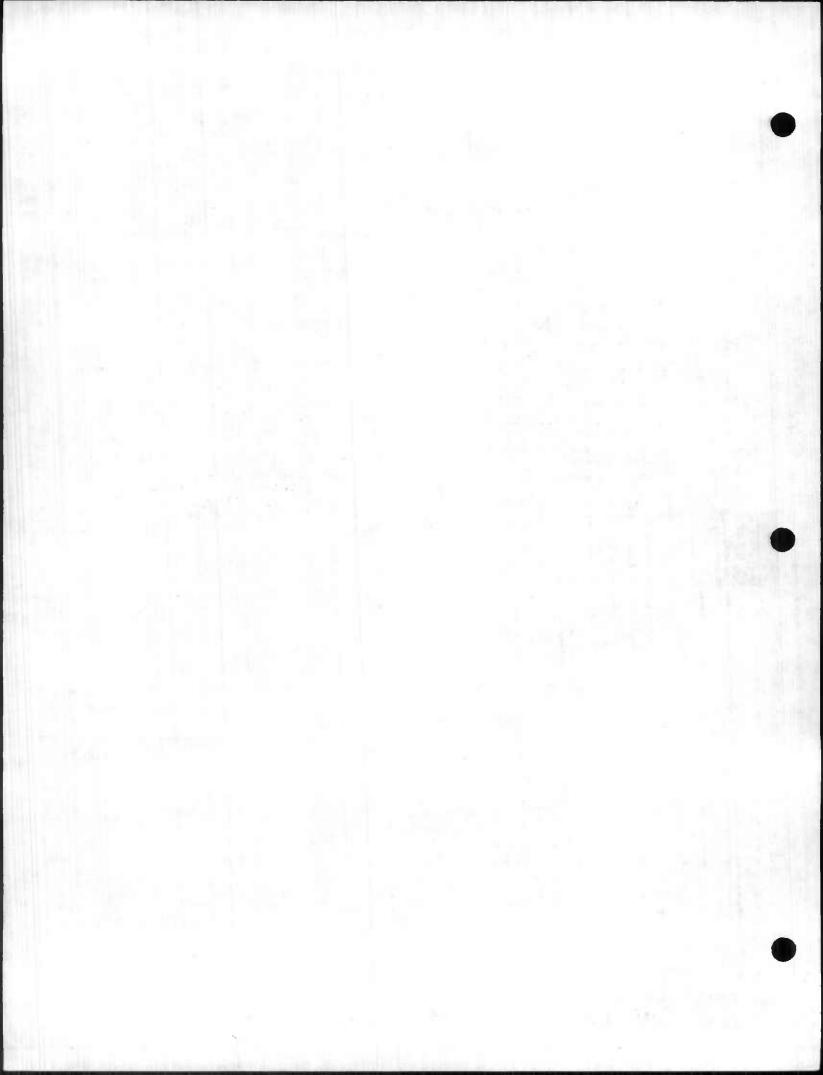


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dale of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** RIESSLER MARGARET J ADVATV d) and Deeth 23,2000 6:48 Am /Medical 4e Facility Name (If not institution, give street end number) 4b City, Town, or Location of Death **Examiner** Franklin Square Mosedale timore enter If Under 24 Hrs. If Under 1 Year 7. Age (In yrs. last birthday) 8. Dale of Birth (Month, Day, Y Feb. 23 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1918 Days Months Hours 1 M 200 219-38-6894 81 Director Maryland Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City. Town or Location r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 10d. Inside City Limits MD Baltimore Essex Director 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 353 Oberle Ave. 21221 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Wes Decedent Ever in U,S. Armed Forces? 11. Marital Status SSLER, MarGARET Bleck, White, etc. 1 Yes 2 XNo If Yes, Give Yeer or Deles: 1 Never Married 2 Married Specify: White 1 Yes 2 No Specify: þ 3 N Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Department of Health and Mental Hygiene.
Important: If Nem 27 Is marked other than "n
any Injury or other traumatic event, the Mental Elementery/Secondery (0-12) College (1-4or 5+) own home Homemaker 6th 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Anne Buzynska Paul Pietruska 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 1606 Howard Ave. Baltimore MAryland Dorothy Zellhofer/daughter 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Melhod of Disposition Dete 20c. Location - City or Town, Stete 1 Burial 2 ☐ Cremetion 3 ☐ Removel from Stete Holly Hill Cemetery 1/27/2000 Baltimore MD. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee 22. Name and Address of Facility Connelly Funeral Home of Essex 300 MAce Ave. Baltimore Md. 23a. Part1. Enler the disease, or complications theil caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Death **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical Lweeks Examiner Due to (or es e consequence of): Examiner The law requires that the death certificate be axecuted Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initialed events resulting in death) Last Due to (or es a consequence of): Box 68760 Completed by Physician/Medical the Due to (or es e consequence of): Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yas 2 No 3 Probably 4 Unknown Cryptococcal Sipsis, Cryptococcal Meningitis, Diabetes Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an eutopsy performed? hypertension, Renal Insufficiency, Atrial Fibrillation Hypothyroidism, Pulmonary Embolism
25. Was case referred to medical exeminer? 1 Yes 1 ☐ Yes 2 ☐ No Division of VItal mental or Attending Physician: hours after death. Be 26. Plece of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Dele of Injury (Month, Dey Year) 27. Menner of Death 26b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Netural 5 Pending 1 TYes 2 No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 281. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 I Homicide within 24 hours a To the Funeral D completely tilled 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) å 29b. Signeture and title of certifie 29d. Date signed (Month, Day, Year) . License numbe 2 who completed cause of death (Item 23a) (Type, Print) Maryland 1000 Franklin timore FEDRO dor 31 Dete filed (Month, Dey, Year) 32. Registrer's Signeture State Registrar JAN 28 2000

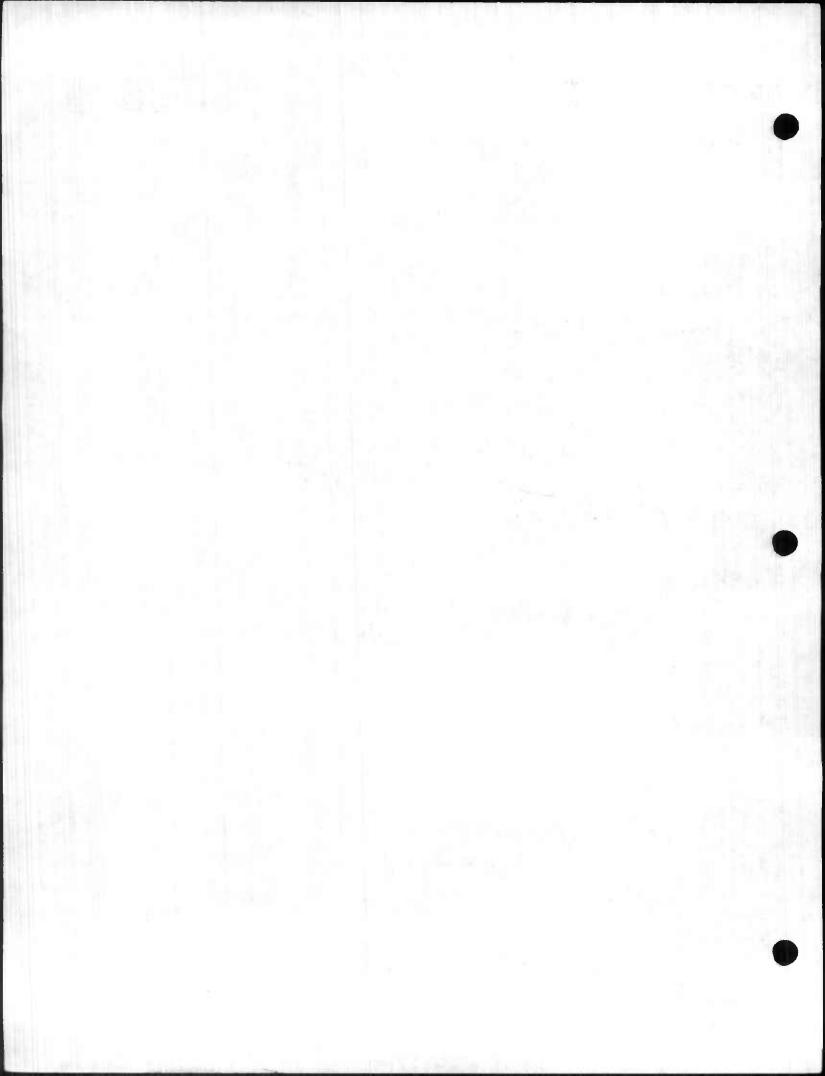
DHMH 16 Rev 6/95

ORIGINAL



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

| | | Cen | tificate of | Death | | Reg. No. | | 3. Time of Deeth | |
|--|---|---|--|-----------------------------|---------------------------------------|--|-----------------------|---|--|
| hysician /Medical | Docedent's Name (First, Middle, Last) DOROTHY | | | NBLATT | | RY 24, 2 | 10:10 AM | | |
| xaminer | 4a Facility Name (If not institution, give street and number) 7 SLADE AVENUE #219 | | lb. City, Town, o BALTIMO | r Location of Death | 4c. County | | | | |
| neral ector | 5. Sociel Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last | t birthdey) Yrs. | If Under 1 Year Months Deys | If Under 24 Hr Hours Mir | | | 9. Birthpi Count | ace (State or Foreign try) NY | |
| | Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, 7 | Town or Loc | eation | | | | 11 | Od. Inside City Limits | |
| Examinar must be notified at by Funeral Director | | TIMORI | | | | | | 1 ☐ Yes 2 💢 No | |
| Director | 10e. Street and Number | | 10f. Zip Code | | | 10g. Citizen of W | hat Coun | try? | |
| a D | 7 SLADE AVENUE #219 | | | 21208 | | U.S.A. | | | |
| by Funeral | 11. Merital Stetus 1 □ Never Married 2 □ Married 3 □ ▼Widowed 4 □ Divorced 12. Was Decedent Ever in U,S. Armed Forces? 1 □ Yes 2 ☒ No It Yes, Give Year or Detes: | | Ves Decedent of H Yes, specify Cubs | | Specify Yes or No rto Ricen, etc.) | 14. Race Black Specify: | - Americ k, White, | | |
| if Health and Mental Hygiene. Item 27 is marked other than "natural", other traumatic event, the Medical Exit To Be Completed by | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4or 5+) | (Giva) | ent's Usual Occup and of work done O NOT use retired | during most of w | 16b. Kind of Bu | lustry | | | |
| To Be Co | 17. Father's Name (First, Middle, Last) | OODMAI | | 18. Mother's N | ame (First, Middle, | Meiden Sumem | e) IKNOW | N) | |
| | | | g Address (Street | | | | | Code) | |
| | JOANNE LEE / DAUGHTER 20a. Method of Disposition 20b. Plea | | YBROOK CO | OURT - G | Date | MD 2105 | | wn State | |
| | 1 Burial 2 □ Cremation 3 □ Removal from Stete cem | etery, crem | atory or other pled E HEBREW | | | | | OWN, MD | |
| important: if fem 27 any injury or other to once. | 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License | | Name end Addre | | | | | | |
| | 11 519 | SOL LEVINSON & BROS 8900 REISTERSTOWN ROAD - PIKESVILLE, M | | | | | | | |
| | 23a. Part1. Enter the disease, or complications that ceused the death. shock, or heart feilure. List only one cause on each line. | | tnterval Between Onset and Death | | | | | | |
| i r | Immediate Ceuse (Finel disease or condition resulting in death) a. Hyperte | M S / V | e he | eart. | diseas | se | | 5 yr | |
| nine | Hypertension | | | | | | | | |
| Medical Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in deeth) Last | ive | hear | t fa | ilure | | | 5 yr | |
| lan | d | | | | | | | | |
| by Physician/M | Part II. Other eignificant conditions contributing to death but not resulting to STEOARTHRITIS | ng in the un | derlying ceuse giv | ren in Pert I. | | Did tobacco use contribute to the cause of dea 1 Yes 2 No 3 Probably 4 Unkn | | | |
| Completed b | | | | | | an eutopsy ormed? | av. | ere autopsy findings ailable prior to mpletion of cause death? | |
| Com | | | | | 10 | Yes 2 No | 10 | Yes 210 No | |
| Be | 25. Was case referred to medical examiner? | | la | | eeth (Check only | one) | | | |
| To Be Comp | | VOutpatient | | 4 LI INDISHING | Home 5 PResi | | | y) | |
| Medical Certification: | 1 Meturel 5 Pending (Month, Dey Year) 2 Accident investigation 3 Suicide 6 Could not be | M 1 Yes 2 No | | | | | | of Route Number. | |
| Certi | 4 Homicide determined 2009 Fields of Injury - Arthoritism building, etc. (Specify) 29a. Certifier 1 Certifying Physician: To the best of my knowle | | | no dole and cla | City or To | wn, Stete) | | | |
| edical | (Check only one) Check only one | | | | | | | | |
| × | 29b. Signeture and title of certifier | , | 29c. Licens | e number | | 29d. Date signed | d (Month, | Dey, Year) | |
| | Nama M Mungh | 20/17 | Print | 1841 | 0 | | | -00 | |
| | 30. Name and address of person who completed cause of death (Item 2: | Jaj (Type, I | therv | ille | MD a | 21093 | | | |
| State | 31. Dete filed (Month, Dey, Year) 32. Registrar's Signatur | e 4 | don't | 1 | .2 - | | | | |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Deeth 3. Time of Deeth 1 Decedent's Name (First Middle Last) Month Eddie Upton Rhoten January 25, 2000 7:00 a.m. 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death 1833 Manchester Road Carroll Westminster If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months 1]ØM 2□ F Yrs. 220-34-6815 Aug. 23, 1908 Carroll Co., Md Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location Md. Carroll Westminster 1 ☐ Yes 2 ☑ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1833 Manchester Road 21157 U.S.A. 14. Reca - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 Married 1 Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Self-employed Farmer 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Neme (First, Middle, Last) Andrew Upton Rhoten Sarah Selina Berwager 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1836 Manchester Road John E. Rhoten - Son Westminster, Md. 21157 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20c. Location - City or Town, State Jan. 28, 2000 4 □ Donation 5 □ Other (Specify) Snydersburg Cemetery Snydersburg, Md. 22. Name and Address of Facility
Eckhardt Funeral Chapel 21. Signature of Funeral Servica Licensee 3296 Charmil Dr. Manchester, Md. 21102 Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting In death) 2/99 - Douth Due to (or as a consequence of) Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or es a consequença of) Due to (or es e consequença of) 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Naturel 2 Accident 5 Pending Investigation 1 □ Yes 2 □ No 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify)

Division of Vital Records, P.O. Box 68760,

physician and the burial-transit The law requires that the death certificate be executed 80 use signed by the e i certificate has b lirector, page 2 s Attending Physician: this funeral after deet Director:

Physician

/Medical

Examiner

Funeral

Director

r 28a-f ahow

"natural", or items 23a or social Examiner must be 7

the Medical

Important: if its any injury or oth

Physician

/Medical

Examiner

Examiner

Physician/Medical

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4 | Homicide

(Check only one)

29b. Signature end title of cartifier

29a. Certifier

Pages 1 and 2 should be filed within 72 hours after death valent of Health and Mentel Hygiene. Int: If Item 27 Is marked other than "natural", or Items 23s

Directo

Funeral

à

Completed

with the Maryland

the Funeral Direcwithin 24 hor To the Fune completely fi 4 2

> State Registrar

31. Date filed (Month, Day, Year)

JAN 28 2000

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end pleca, and due to the cause(s) and manner as stated.

29c. License number

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end piece, end due to the cause(s) and manner stated. 29d. Dete signed (Month, Day, Year)

00

30. Name and address of person who completed cause death (Item 23a) (Type, Print)

32. Registrar's Signature

AND STREET ST - Commercial 51 The Property of the Park hen the town our self-THE TAX AND THE SAME AND PROPERTY OF THE SAME AND A SAM

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middla, Last) 3. Time of Death 20, January 2000 2:00 P.M.

IIIInois

UNKNOWN

Approximate Interval Between Onset and Death

24b. Wera autopsy findings available prior to completion of ceuse of death?

1 ☐ Yes 2 ☐ No.

January 21, 2000

10d. Inside City Limits

1X Yes 2 □ No

use as the burial-transit The law requires that the death certificate be executed pue Box 68760. P.O. detached 94 3 director, page 2 should be det of Vital Records,

Physician John F. Rayfield /Medical 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6307 Red Cedar Place Baltimore N/A If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 1-8-1933 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplaca (State or Foreign * Funeral Days Hours 1 M 2□ F Yrs. Director 345-26-7524 Usual Residence of Decedant with the Maryland 10a. Stata 10b. County 10c. City, Town or Location 28a-f ahow traumatic avant, the Medical Examiner must be notified at Maryland N/A Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 2 U. S. A. Funeral 21209 Peges 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or Items 23. 6307 Red Cedar Place 12. Was Decedent Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Yas 2 □ NOWII If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0020 Specify: White 1 ☐ Yes 2X No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Il Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) V. A. Hospital Engineer 5+ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surnama) Be Alvira Hugh Rayfield 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Department of Health a Important: if Itam 27 is any injury or other trait page. Eastbend Court, Abingdon, Maryland 21009 3211 Mrs Rhonda Fleischmann (Step DTR) Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, crematory or other pleca) 20c. Location - City or Town, Stata Data 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1-25-00 Towson, Maryland Hilltop Service Corp. 21. Signature of Funeral Service Licensee 22. Nama and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road, Towson, Md. nter the mode of dying, such as cerdiac or respiretory arrest, 23a. Part1. Enter the disaasa, or complications that ceused the death. Do not enter shock, or heart failure. List only one ceuse on each line. **Physician** Hohoscionotic CASIONDScuper /Medical Immediate Ceuse (Final disease or condition resulting in death) **Examiner** Due to (or as a consequence of): Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated evants Due to (or as a consequence of): Due to (or as a consequence of): resulting in death) Last Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yaa 2 No 3 Probably 4 Unknown Be Completed by 24a. Was an autopsy parformed? DHOKEN 1 Yes 2 No al or Attending Physician: The safer death.

Il Director: After this certificate of in by the funeral director, pa 25. Was cese referred to medical 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Nesidence 6 Othar (Specify) 1 Yes 2 No Certification: To 27. Manner of Death 1 Natural 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Division 5 Pending investigation 1 Yas 2 No 2 Accident 28f. Location (Street and Number or Rure! Route Number, City or Town, State) 3 Suicide 6 Could not be To the Hospital or Atte within 24 hours after de .To the Funeral Directo completely filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Phyalcian: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.

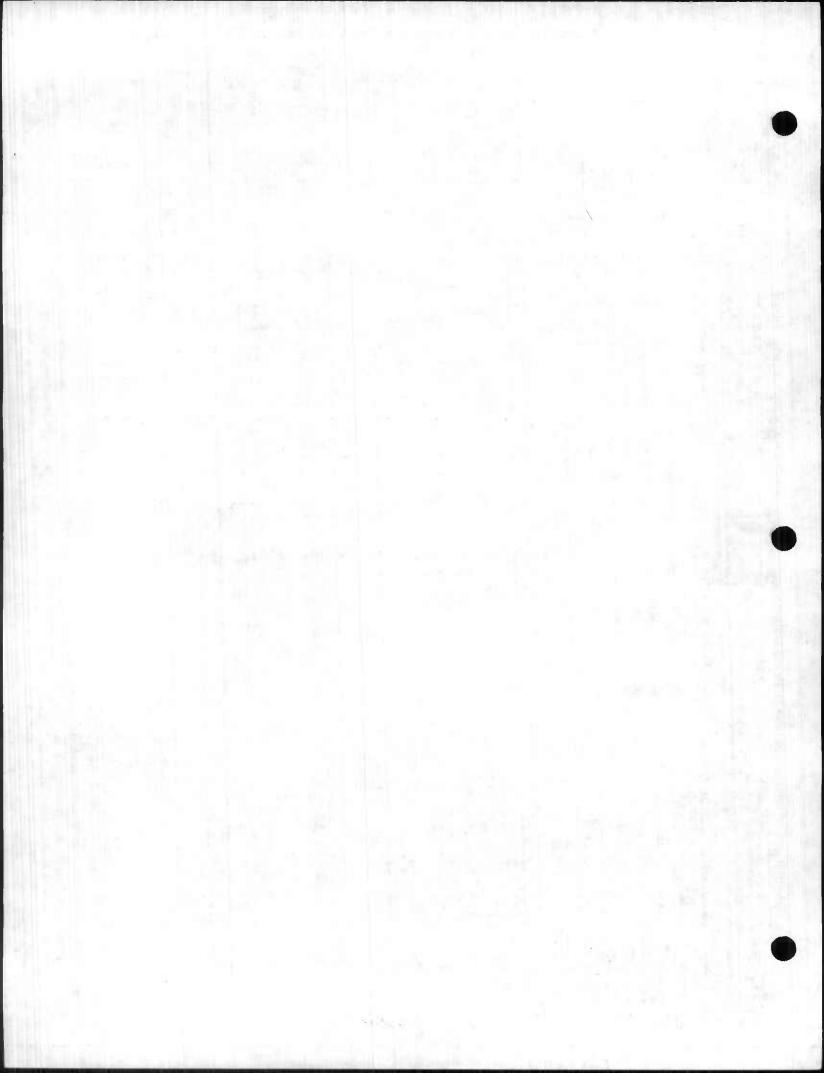
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medicai 29a. Cartifian and mannar stated. 29b. Signature and title of certifier 29c. License number 29d. Data signed (Month, Day, Year)

O.C.M.E. 30. Name and address of parson who completed causa of death (item 23a) (Type, Print) MARYDRIM Kutoh Mp

111 Penn Street, Baltimore, Maryland 21201 32. Registrer's Sig

State Registrar 31_Date filed (Month, Dey, Year)

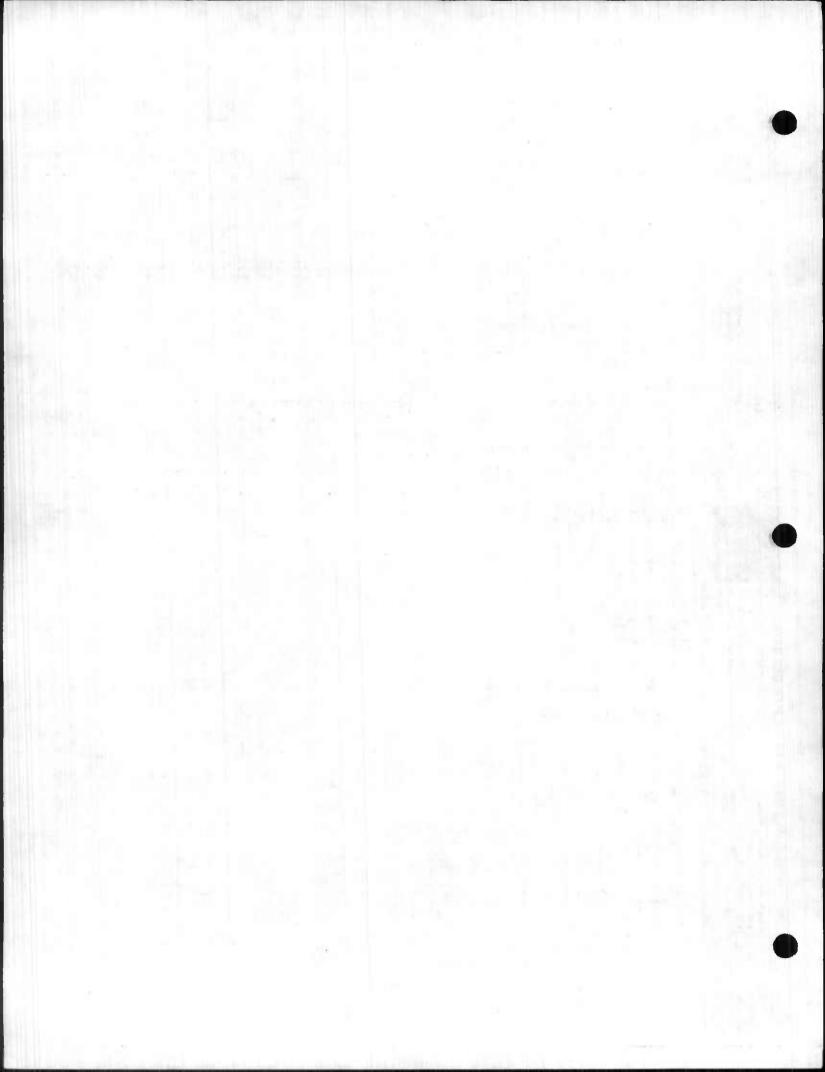
JAN 2.8 2000



State of Maryland / Department of Health and Mental Hygiene 0 0 0 0 0 1

| the burner and the bu | suel Residence of Decedent Da. Stete 10b. County MD. BALTIMO De. Street and Number 4503 HAWKSBURY Maritel Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Ed (Specify only highest gra Elementary/Secondery (0-12) -12- Tather's Neme (First, Middle, Last) CHARLIE ROBINSO De. Informent's Neme/Relationship (1) ISABELLE GRANT (De. Method of Disposition 12 Burial 2 Cremation 3 Disposition 13 Burial 2 Cremation 3 Disposition 14 Donetion 5 Other (Specify 1. Signeture Funerel Service Licen 3a. Part Enter tha disease, or compshock, or heart feilure. List only the state of the s | RD. In the street and number) RD. In the street and number) RE RE RD. In the street and number) RE RE RD. In the street and number) RE RD. In the street and number) RE RE RD. RE | 86 10c. City, PII Ever in U,S No 5+) 20b. Pic. Ce | 16a. Deced (Give tife. L NU 19b. Mellin 47 C ace of Dispo metery, cren ID RID | Was December 101. Zip Was December 11 Yes, special Yes, | Code Code 2120 Sent of hority Cub at Occupant done se retires | Hours Min 18 Hours Min 18 Mother's Na | Specify Yes or Noto Rican, etc.) Be a Dete of Bi (Month, b) 12-1 Specify Yes or Noto Rican, etc.) Specify Yes or Noto Rican, etc.) | th 4c. County BAL' The second of the second | of Death TIMOR: 9. Birthple Countr 10. Vhat Countr e - America k, White, el siness/Indu | S.C. S.C. d. Inside City Lim 1 □ Yes ② nor indian, tc. K. Limits and the city Lim | |
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| the burnier and the burnier an | 4503 HAWKSBURY Social Security Number 217-22-0120 Suel Residence of Decedent See Street and Number 4503 HAWKSBURY MD. BALTIMO See Street and Number 4503 HAWKSBURY Maritel Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Ederative only highest grave only highest grave Elementary/Secondery (0-12) -12- 7. Father's Neme (First, Middle, Last) CHARLIE ROBINSO 99. Informent's Neme/Relationship (1) ISABELLE GRANT (1) 199. Method of Disposition 10 Burial 2 Cremation 3 Security of the Company of | RD. In the street and number) RD. In the street and number) RE RE RD. In the street and number) RE RE RD. In the street and number) RE RD. In the street and number) RE RE RD. RE | 86 10c. City, PII Ever in U,S No 5+) 20b. Pic. Ce | Yrs. Town or Lo KESVII 16a. Decece (Give life. II) 19b. Mellin 470 ace of Dispo | Months CLE 101. Zip Was Decer In Yes, spen In Yes JRSE Ing Address J4 HAI | Code Code 2120 Sent of hority Cub at Occupant done se retires | PIKESVI If Under 24 Hrs Hours Min 18 Hispanic Origin? (5 an, Mexican, Puer Specify: pation during most of wo | Location of Dear LLE 8. Date of Bi (Month, b) 12-1 Specify Yes or N to Rican, etc.) whing me (First, Middle E QUATT) ural Route Numb | th 4c. County BAL' rth year) 7-13 10g. Citizen of V USA 14. Race Blac Specify 16b. Kind of Bu HEAL' g. Maiden Surnam BUM per, City or Town, | of Death TIMOR: 9. Birthple Countr 10. Vhat Countr e - America k, White, el siness/Indu | E ace (State or Fonny) S.C. d. Inside City Lim 1 Yes 203 ny? In Indian, tc. K. | |
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| chican and the burnal-transit th | | plications that caused | 21. Signeture of Funerel Service Licensee 22. Neme and Address of Facility PHILLIPS FUNERAL F 1721-27 N. MONROE ST. BALTIMORE, MA | | | | | | | | | |
| the burial-transit the burial-tr | | one cause on each lin | the death. | Do not ente | er the mod | e of dyi | ng, such as cardia | c or respiratory | arrest, | , 1 | Approximate Interval Between Onset and Death | |
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| at o | 1 ☑Netural 5 ☐ Pending 2 ☐ Accident investigation | (Month, Day | rear) | Injury | М | | Yes 2 No | | | | | |
| | 3 Sulcide 6 Could not be determined | 28e. Plece of Injubuilding, etc | ury - At hon c. (Specify) | ne, ferm, str | reet, factory | , office | | 28f. Location City or To | (Street and Numb wn, State) | er or Rurat | Route Number, | |
| pletely fill | | ysician: To the best of niner: On the basis of end menner ste | examination | | | | | | | | | |
| E | b. Signeture and fitte of certifier | One monitor ste | | | 290 | . Licens | se number | | 29d. Dete signe | d (Month, D | ay, Year) | |
| - 8 | The state of the s | | | | | | 004 400 | -17 | 1/24/00 | | *** | |
| | Richard a. B | | | | | / 204 | OCT HOL | 710~ | 151/00 | | | |
| 30. | | completed cause of d | | 23a) (Type, I | | | | | | | | |

DHMH 16 Ray 6/95

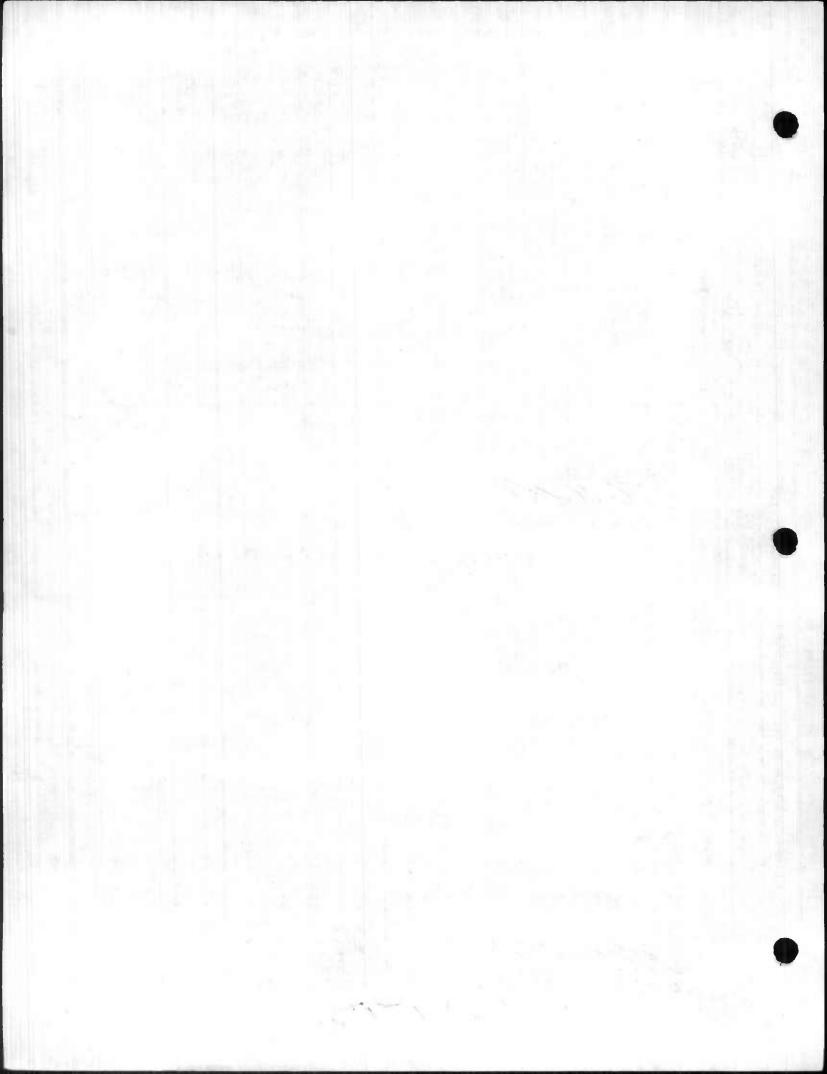


Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

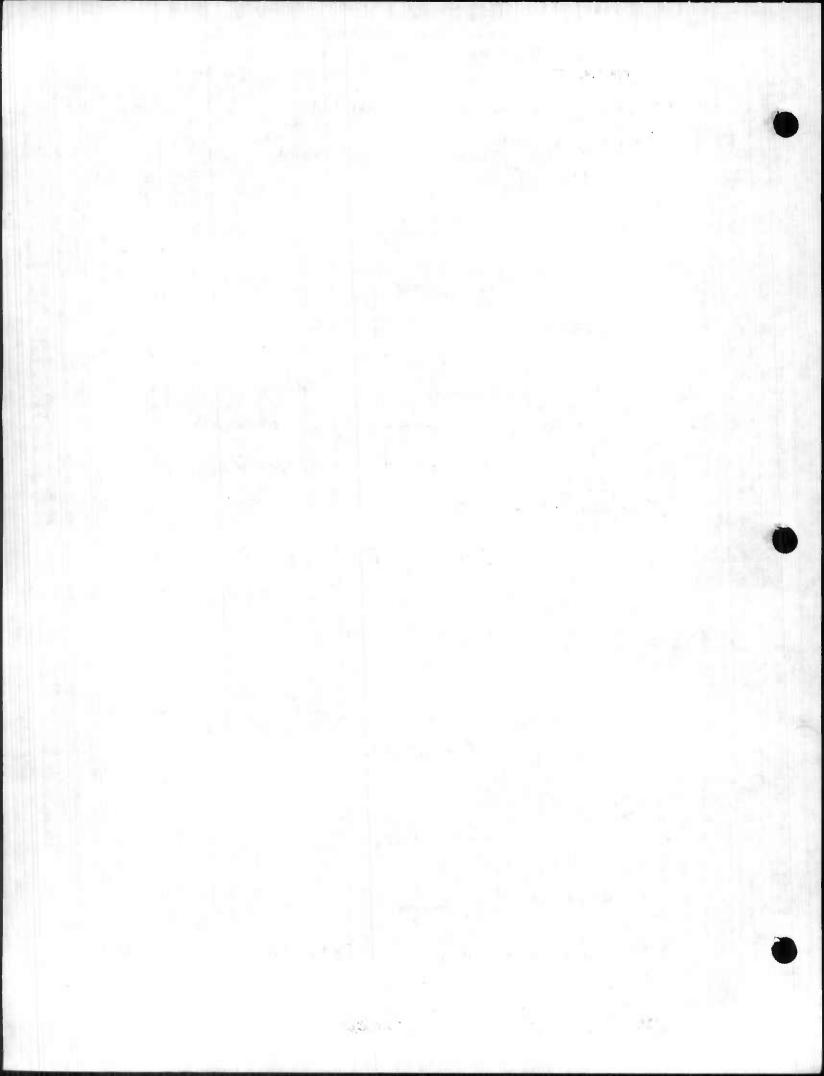
State of Maryland / Department of Health and Mental Hygiene 1 1 2 1 9 2

| | Decedent's Neme (First, Middle, Las | it) | 061 | tificate of | Death | 2. Date of Death | | 3. | Time of Death |
|--|--|---|---|--|---|---|-----------------------------------|-------------------------------------|--|
| Physician /Medical | Dominga Ville | anera Sol | Lis | | | January | 24, 20 | Year | 2:30 PM |
| Examiner | 4a Facility Name (If not institution, give | 1777 | | 4 | 6b. City, Town, or Lo | cation of Death | 4c. County | | |
| | 9 Harebell Ct., | , Apt. A-2 | | | Baltimo | | | timore | |
| Funeral Director | 023-90-3301 | D | (In yrs. last birthday) | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Aug. 4, | 1913 | 9. Birthplace Country) Phulip | (State or Foreign PLNES |
| | Usuel Residence of Decedent 10a. State 10b. County | | 10c. City, Town or Lo | cation | | | | 10d. Ir | nside City Limits |
| notified | Maryland Baltin | nore | Ва | ltimore | | | | 1 | Yes 2 No |
| Director | 10e. Street and Number | | | 10f. Zip Code | | 10 | g. Citizen of W | hat Country? | |
| 10 | 9 Harebell Ct., | Apt. A-2 | | 212 | 236 | 400 | u.s. | A. | |
| by Funeral | 11. Marital Status 1 Never Married 2 Merried 3 X Widowed 4 Divorced | 12. Wea Decedent Ev Armed Forces? 1 Tyea 2 No if Yes, Give Year or Dates: | | Ves Decedent of H Yes, apecify Cubs | lispanic Origin? (Sp an, Mexican, Puerto Specify: | ecify Yes or No- Rican, etc.) | | - American In k, White, etc. | ite |
| Be Completed | 15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12) 7th Grade | ucation de completed) College (1-4or 5+ | | ent's Usual Occup kind of work done o OO NOT use retired emaker | ation during most of work f) | ing 1 | 6b. Kind of Bu | siness/Industry | |
| Ö | 17. Father's Name (First, Middle, Last) | | 110111 | enaicet | 18. Mother's Name | (First, Middle, M | | | |
| To Be | Pedro Villane | ra | | | | | Clasica | | |
| - | 19e. Informant's Neme/Reletionship (7 | ype, Print) | 19b. Meilin | g Address (Street | and Number or Run | al Route Number, | City or Town, | State, Zip Code | 9) |
| | Mrs. Remedios Men | doza (dght | r) 9 Ha | rebell C. | t., Apt. | A-2, Bal | timore, | MD 2 | 1236 |
| 6 | 20a. Method of Disposition | | 20b. Place of Dispo- | | | - | Oc. Location - 0 | | State |
| | 1 Burial 2 Cremetion 3 1 4 Donation 5 Other (Specify | | Green Mou | | | /29/00 B | Baltimo | re. Mar | uland |
| 8000 | 21. Signature of Funerel Service Licens | 500 | 22 S | Name and Address | ss of Facility Funeral | Home. In | c. | | |
| | 23a. Pert1. Enter the disease, or comp shock, or heart failure. List only of | lications that caused to | ne deeth. Do not ente | 105 Belain | ir Rd., Bo | utumore | MU | 21236 | roximate |
| for use as the burial-transit | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b | ue to (or as a conseque to (or as a consequence) | uence of): uence of): | | | | | |
| clan | | d | | | | | | | |
| Physician/M | Part II. Other significant conditions co | ntributing to death but | not resulting in the ur | derlying cause giv | en in Pert I. | 23b. Did tot | 40 | | cause of death? |
| Completed by Physic | | | | | | 24a. Was an perform | | evailable | utopsy findings e prior to tion of cause |
| Idmo | | | | | | 457 | obar. | of death | 1? |
| Com | 25. Was case referred to medical | | | | 00 0 | 1 Yes | , , | 1 ∐ Yes | s 2□ No |
| director, page 2 s | examiner? | Hospital: | 2 ER/Outpatien | 3□ DOA Oth | er: 4 D Numing Ho | ma 5 Resider | | y (Cnack) | |
| _ | 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation | 28a. Date of Injury (Month, Day) | 28b. Time of | 28c. Injun Wor | | 28d. Describe how | | | |
| Certification: | 3 Suicide 6 Could not be 4 Homicide determined | 28e. Place of Injury building, etc. | y - At home, ferm, stri (Specify) | | | 28f. Location (Str. City or Town, | | er or Rural Rou | ite Number, |
| Completely filled in by the funeral Medical Certification: | 29e. Certifier (Check only one) 1 Certifying Phy | raician: To the best of iner: On the basis of each manner stete | camination and/or inv | occurred at the tin estigation, in my o | ne, date and place, pinion, death occurr | and due to the car ed at the time, da | use(s) and mai te and plece, a | nner es stated. and due to the | cause(s) |
| Me Me | 29b. Signature and title of certifier | | | 29c. License | | | d. Date signed | | Year) |
| | 10000 | and , | > | 22: | 3967 | 7 | 1-27. | 00 | |
| | and of the second | and to esues hetalamo | th (Item 23s) (Type I | Print\ | | | | | |
| 1 | 30 Name and address of person who of | | 10 8731 | 15 8 CA | ir up. | BALTO | - MI | 2/2 | 36 |

DHMH 16 Ray 6/95



| | | AMEND#19b PER F.H. G77 | | | Certificate of | | | a. No. | 020 | 93 |
|---|------------------|--|--|------------------------------|---|---|--|-----------------|-----------------------------------|-------------------------------|
| | | 1. Decedent's Nama (First, Middle, Las | | • | , _ | | 2. Date of Death | | | ima of Death |
| Physici /Medic | | ESTELL | -F CL | 50 | SMIT | h. | Month | 19 201 | Year O | IPM. |
| Examir | | 4a Facility Name (If not institution, give | street and number) | | | 4b. City, Town, or Loc | | 4c. County | of Death | |
| | | | E W | | Williado d Voca | BALTIM | ORE CI | TY | NIA | |
| Funeral Director | | 5. Social Security Number 6. S 183 16 0 1444 4 1 Usual Residence of Decedent | D | (In yrs. last bii | thday) If Undar 1 Yaar Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day,) 7-/7-/ | | 9. Birthplace (Country) | State or Foreign |
| with the Maryland a or 28a-f show Lea noutled at | | 10a. State 10b. County M D N/A | 1 | BA CT | | | | 7 | | ide Offy Limita Yes 2 □ No |
| th with the M 23e or 28e-f | Funeral Director | 10e. Street and Number 823 N. LUZERN | E AVE. | | 101. Zip Code 2 / 2 | 05 | 100 | g. Citizen of W | | |
| 5-0020 72 hours after death natural; or fems 23 | P | 11. Marital Status 1 Neyer Marriad 2 Married 3 Widowed 4 Divorced | 12. Was Decedant Ev Armed Forces? 1 Yas 2 12 No If Yes, Give Yaar or Datas: | | 13. Was Decedant of If Yes, specify Cub 1 □ Yes 2 ☑ No | Hispanic Origin? (Spec an, Mexican, Puarto R Specity: | ify Yes or No- ican, atc.) | Black | American Indik, White, etc. | |
| 5-0 72 h | Completed | 15. Decedent's Ed (Specify only highast gra | ucetion da completed) | 16a. | Decedent's Usual Occu (Give kind of work done | during most of working | 9 16 | 6b. Kind of Bu | siness/Industry | 0.10 |
| within within than | Idu | Elementery/Secondery (0-12) | College (1-4or 5+) | | life. DO NOT use retire | MAKER | | DOM ES | STIC | |
| 2697 | | 17. Father's Name (First, Middle, Last) | 11/4 | | HOME ! | 18. Mother's Name | | | | |
| Maryland d 2 should be file h end Mental Hy le marked oth traumatic event | m | PHENIOUS MADIS | EN DANU | EL | | CARRIE | | | | |
| 2 should be mark | - | 19a. Informant's Name/Relationship (7 | | | . Mailing Address (Stree | | | | State, Zip Code |) |
| 2 2 2 2 | | DASTOR P.M. S | mith | 144 | 40 810 N | LUZERA | IE. AVE | BA CH | m D 2 | 1205 |
| Ore Here | | 20a. Method of Disposition 1 ☑ Burlal 2 ☑ Cramation 3 ☑ | Romoval from State | cemete | Disposition (Name of ry, crematory or other pla | ica) | | | City or Town, Si | |
| Liment Mary Sury Sury Sury Sury Sury Sury Sury Su | | 4 □ Donation 5 □ Other (Specify | | WAYM | AN AIME CH | URCH YARA | 1/27/00 | ENFIE | Id N. | .C, |
| Baltimore permit. Pages 1: Dispariment of He important if item any injury or oth once. | | 21. Signature of Etineral/Service Licen | a Ri | 2 | 22. Name and Addre | ONERAL HO | / | 129N. | CAROLI nD 2/2 | NE ST |
| 2 | | 23a. Part1. Enter the disease, or comp shock, or heart failura. List only | olications that caused the | ne death. Do | not enter the mode of dy | ng, such es cardiac or | respiretory arres | st, | Inten | oximate val Between |
| Physician | | and and an arrangement | | | | | | | | t and Death |
| / /Medical Examiner | | Immediate Ceuse (Finel disease or condition resulting in death) | . <u>Co</u> | NGE | STIVE | NEA | RTF | AILV | KE S | my. |
| | 6 | | | | consequence of): | (- (- 0) | | 1 | 3 | V= 10 |
| beth beth | Examiner | Securetially list conditions | 4 | HEN | consequence of): | YOCARI | DAPA | MY |) > | YEARS |
| 68760, cata be executed physician and it the burial-transit | Exa | Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying | | 00 to (01 as a | consequence or. | | | | | |
| 68760, filtesta be expressed to physician as the burian | 8 | Cause (Disease or Injury that initiated events resulting in death) Last | C | ue to (or as e | consequence of): | | | | | |
| 10 10 | | Tossing in dealing East | d | | | | | | į. | |
| O. Box (see death certify the attending thed for use a | Physician/M | | d | | | | | | 1 | |
| | ysic | Part II. Other significant conditions or | entributing to death but | not resulting i | n the underlying cause gi | ven in Part I. | 23b. Did tob | acco uaa con | tribute to the c | auaz of death? |
| - = > 6 | F | ATRIJ | YL F | FIR | RILLA | TON | 1 Yai | 2 No | 3 Probably | 4 Unknown |
| | d by | 0.0 | | | | | 24a. Was an | autopsv | 24b. Wara au | topsy findings |
| / D // | ete | BLEA | ST | XN | CER | | performe | ed? | avallable completi of death | on of cause |
| Rec The law ate has b | Completed | | | | | | 1 ☐ Yes | 200 No | 1 ☐ Yas | 20 No |
| Vital Inside | | 25. Was case referred to medical | | | | 26. Place of Death | | 14 | 10 100 | 27110 |
| of Vita Physician: this certific | ToB | examiner? | Hospital: | 2 ERVOI | stpatient 3 DOA Of | her: 4 Nursing Hom | | | er (Specify) | |
| On of ding Phys h. Aftar this funeral di | | 27, Menner of Death 1 Natural 5 □ Pending | 28a. Dete of Injury (Month, Day) | | Fime of 28c. Injury | ry at 2 | 8d. Describe how | v injury occurr | ed | |
| Attending or death. | atic | 2 ☐ Accident investigation | | | | Yes 2□No | | | | |
| Division or Attending after death. Director: After d in by the fune | Certification: | 3 Suicide 6 Could not be determined | 28e. Plece of Injury building, etc. | y - At home, fa (Specify) | rm, street, factory, office | 21 | 8f. Location (Stre City or Town, | | er or Rural Rou | e Number, |
| oral Delin | 2 | and continue of a state of | of fact To the book of | | | in a data and also a | ad due 6 - 6h a | | | |
| Hos 24 ho Fun etaly | edical | | | xamination an | dor investigation, in my | | | | | ause(s) |
| Division of Vital Rivibion of Vital Rivibio Bours and Attanding Physician: The Inviting 4 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page | | 29b. Signature and title of certifier | Λ | | 29c. Lican | sa number | 29 | d. Data signed | i (Month, Day, 1 | (ear) |
| - 5 - 0 | | Ann | Sel | IM | 1 | 16711- | , | 1/2 | 4/00 | |
| a | - | 30. Name and address of person who | completed ceuse of dea | ith (Item 23a) | (Type, Print) | 14)4 / | | 1 | 1100 | |
| | | S AMSEL | 1000 CA | THED | RAL C | T BA | LTIMO | REN | 10 S13 | -01. |
| Sta | te | 31. Data filed (Month, Oay, Year) | 92 Registrar | s Signature | | | | | | |
| Registr | | | | | | | | | | |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Doris Swomley 01 20 2000 920 am 4a. Facility Name (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death Future Care Homewood Baltimore Baltimore City 5. Social Security Number If Under 1 Year if Under 24 Hrs. Hours Min. 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dey, Birthplace (State or Foreign Country) (Month, Dey, Year) 10-08-23 Months Days Hours 1 ☐ M 2 💢 F 77 Yrs. 216 12 2437 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d, inside City Limits 1 X Yes 2 □ No Maryland Baltimore City Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 524 N. Charles Street (apt. 1218) 21201 Unites States 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - American Indian, Black, White, etc. I ☐ Yes 2 🔀 No f Yes, Give Year or Dates: 1 Never Married 2K Married 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Insurance 12 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) William Kraft Mildred Bruchey 19a. Informent's Name/Relationship (Type, Print) 19b. Malling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Swomley /husband Mahon 524 N. Charles Street (apt.906), Baltimore, MD. 2120 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Buriai 2 □ Cremetion 3 □ Removal from State 4 □ Donetlon 5 □ Other (Specify) 1-31-00 Baltimore, Maryland Loudon Park Cemetery 21. Signature of Funeral Service Apensee 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part1. If or the disease or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deeth Immediate Cause (Final disease or condition resulting In death) Dinbetes Deby Mature
Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hyzerten cir Due to (or as a consequence of):

P.O. Box 68760. Records, Division of Vital

Examiner Examiner the Hospital or Attanding Physician: The law requires that the death certificate be axecuted physiclan s the burial Physician/Medicai 8 Completed by Be 2 filled in by the funeral Medical Certification: To the Hospital or Attandi within 24 hours after death. To the Funeral Director: A completely filled in by the fo

Physician

/Medical

Examiner

Funeral

Director

"natural", or itama 23a or 28a-f show

Pages 1 and 2 should be filed within 72 hours after of and of health and Mental Hygiene.
Int: If fem 27 is marked other than "natural", or ital inty or other traumals event, I'm Medical Exponent. Inty or other traumals event, I'm Medical Exponent.

permit. Page Department of Important: If any injury or once.

Physician

/Medical

Baltimore, Maryland 21215-0020

Directo

Funeral

by

Completed

Be

death with the Maryland

| Pert II. Other significant conditions of | ntributing to death but not re | sulting in the underly | ing ceus | se given In Part I. | | 23b. Did tobacco use con | ntribute to the cause of death? 3 Probably 4 Unknown |
|---|---|--|-------------------------|---|-------------------|---|---|
| | | | | | | 24a. Was an autopsy performed? | 24b. Were autopsy findings evellable prior to completion of ceuse of death? 1 □ Yes 2 □ No |
| 25. Was cese referred to medicel examiner? | | | | 26. Place of D | eath (C | heck only one) | |
| 1 Yes 2 No | Hospitai: 1 ☐ Inpatient 2 ☐ | ER/Outpatient 3 | DOA | Other: 4 Nursing | Home | 5 ☐ Residence 6 ☐ Oth | er (Specify) |
| 27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation | | 28b. Time of Injury | 28c. | Injury at Work? | 28d. | Describe how injury occurr | red |
| 3 ☐ Sulcide 6 ☐ Could not be 4 ☐ Homicide determined | 28e. Place of Injury - At h building, etc. (Speci | | ctory, of | fice | | Location (Street and Numb City or Town, State) | er or Rurel Route Number, |
| 29a. Certifier 1 Certifying Phy (Check only one) 2 Madical Exam | raician: To the best of my kno inar: On the basis of examina and manner stated. | owledge, death occur ation and/or investiga | rred et ti ation, in | he time, date and plac my opinion, death occ | ce, and courred a | due to the cause(s) end me t the time, date and piace, | onner es stated. and due to the cause(s) |
| 90h Cignoture and title of annilling | | | 00- 13 | | | 00.15.1 | 1 04 11 0 11 1 |

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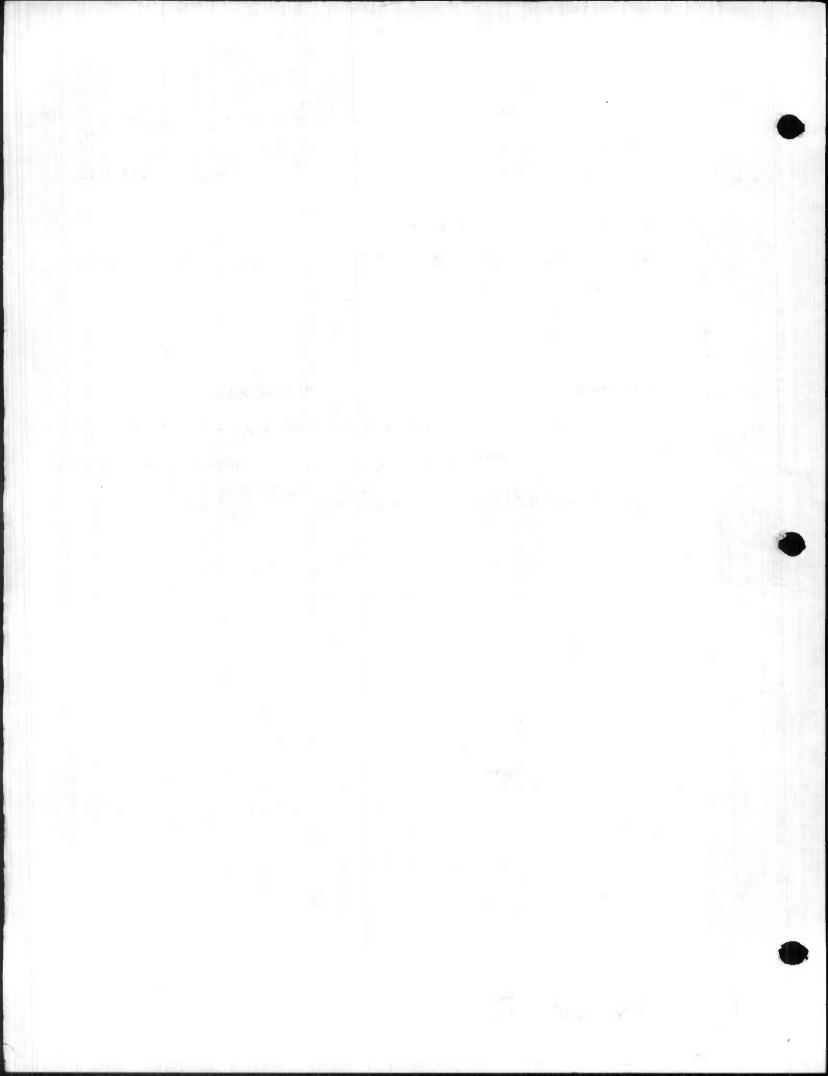
Ente 308, Baltimore MD 21201

State Registrar

30. Name end eddress of person who completed ceuse of deeth (item 23a) (Type, Print)



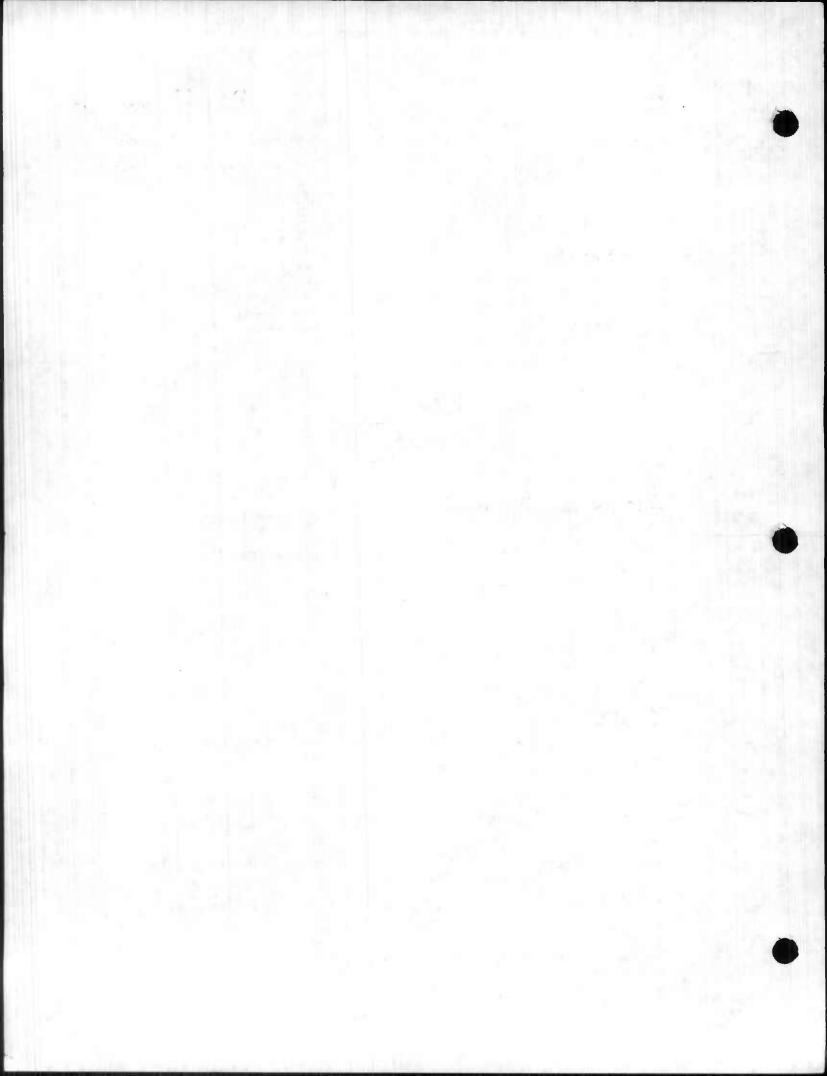
SHOALD A. HACHMI 821 N. ENTOW 31. Date filed (Month, Day, Year) JAN 2 8 2000



State of Maryland / Department of Health and Mental Hygiene O O

| | | nt's Nam | 18 (FIFST, MIC | ddle, Last) | | | | | | | 2. Date of De | Reg. No. | Year | 3. Time of Death |
|---|--|--|--|--|---------------------------------|--|--|--|-------------------|--|--|---|--|--|
| ician dical | Iren | е | Jı | une | S | avino | | | | | 01 | 27 | 2000 | 6:29am |
| niner | 4a Facility | Name (| lf nof institu | tion, give s | treef and nu | um <i>ber)</i> | | | 41 | b. City, Town, or Lo | cation of Deat | h 4c. Cou | unty of Death | h |
| | | | | | | | Center | | | Baltimor | | | ltimor | |
| al or | | 22-6 | 460 | 6. Sex 1□ | M 2□ X F | 7. Age (In y | rs. last birthday) Yrs. | Montha Da | ear ays | Hours Min. | 8. Date of Bir (Month, De 6/20/1 | 926 | 9. Birth Con Ball | hplace (State or Foreig unity) timore |
| | 10a. State | | 10b. Cour | nty | | 10c. | City, Town or Lo | ocation | | | | | | 10d. Inside City Limits |
| oto | Md. | | N. | /A | | | Baltimor | re | | | | | | 1 Ves 2□No |
| Funeral Director | 10e. Stree | and Nu | mber | | | | | 10f. Zip Cod | de | 100 | | 10g. Citizen | of What Co | untry? |
| ĕ | 9537 | Powd | erhori | n Lan | е | | | 212: | 34 | | | US | SA | |
| | 11. Marita | Status | | 1 | 12. Was Dec | cedent Ever in | n U,S. 13. | Was Decedent If Yes, specify (| of His | spanic Origin? (Spin, Mexican, Puerto | ecify Yes or No Rican, etc.) |)- 14. I | Race - Amer Black, White | rican Indian, e, etc. |
| ì | 3 □ W | | ied 2 ☑ M 4 □ Divorc | | 1 Yes If Yes, G Year or I | 2 No live Dales: | | 1 ☐ Yes 2 🔀 | | Specify: | | | | ite |
| | | (Spec | 15. Deced | lent's Educ | ation completed |) | 16a. Dece | dent's Usual Oc | ccupa | ition luring most of work | ina | 16b. Kind o | of Business/! | Industry |
| | | tery/Seco | ondary (0-12 | | | (1-4or 5+) | life. | DO NOT use re | stired) | | | C1 | ectro | nio |
| | | 2 | | | | | | Assemb1 | er | 40.44.45.4.41 | 45° 4 84° 4 W | | | IIIC |
| | | | (First, Middl | | | | | | | 18. Mother's Name | | | | |
| | Ounk | | enry P | | | | | | | Gertruc | | | | T 0:11 |
| | | | ame/Relatio | | | | | | | and Number or Run | | | | |
| | Paul 20a. Meth | | Savino | - Hus | sbana | 20 | 953/ b. Place of Dispo | | | n Lane, I | Date Date | | | 34 Town, State |
| | | | Crematio | n 3 🗆 Re | emoval from | State | cemetery, crea | matory or other | place | - 1 | | | | |
| | | | 5 Other | | | F | arkwood | | | | 31/2000 | Balti | more, | Md. |
| | 21. Signa | ture of Fu | ineral Service | ce License | 4- | | 22 | 2. Name and Ad 5305 | | s of Facility Le | | | | eral Home 1234 |
| г | | | | ist only on | e cause on | each line. | eath. Do not ent | ter the mode of | dylng | g, such as cardiac | or respiratory a | rrest, | | Approximate Interval Between |
| Jer | Immediat disease o resulting | r conditio | (Final | ist only on | e cause on | each line. | brovas | | | a, such as cardiac | 2 | rrest, | | Approximate Interval Between Onset and Death |
| edicai | Sequential in any, les cause. E Cause (D that initiat resulting) | ally list co ding to in nter Under isease or | (Final on onditions, onditions, one of the original o | a b c. | e cause on | tria Due to | bovas Ogas a conse | quence of): | | | 2 | rrest, | | Interval Between |
| | Sequential any, leacause. E Cause (D that initial resulting) | ally list co ding to in ally list co ding to in nter Unde isease or red events in death) i | (Final on onditions, namediate orlying Injury s Last | a b c. | * | Due to | logas a consecutivo (oraș a consecutivo) | quence of): | te | accis | lent | | s contribute | Interval Between |
| LIN SICIAL MICAICAL | Sequential if any, lea cause. E Cause (D that initiat resulting if Pert II. Ott | ally list co ding to in ally list co ding to in nter Unde isease or red events in death) i | (Final on onditions, namediate orlying Injury s Last | a b c. | * | Due to | o (or as a consec | quence of): | te | accis | lent 23b. Did | | | triterval Between Onset and Death |
| Physician/Medical | Sequential if any, lea cause. E Cause (D that initiat resulting if Pert II. Ott | ally list co ding to in ally list co ding to in nter Unde isease or red events in death) i | (Final on onditions, namediate orlying Injury s Last | a b c. | * | Due to | o (or as a consec | quence of): | te | accis | 23b. Did | tobacco usa | 90 3□P1 | triterval Between Onset and Death |
| Physician/Medical | Sequential if any, lea cause. E Cause (D that initiat resulting if Pert II. Ott | ally list co ding to in ally list co ding to in nter Unde isease or red events in death) i | (Final on onditions, namediate orlying Injury s Last | a b c. | * | Due to | o (or as a consec | quence of): | te | accis | 23b. Did | tobacco uas Yes 2DN | 24b. 1 | triterval Between Onset and Death to the cause of death robably 4 Unknow Were autopsy findings available prior to completion of cause |
| 3e Completed by Physician/Medical Examiner | Sequential fany, leacause. E Cause (D that initiat resulting) | asserater | (Final on onditions, namediate orlying Injury s Last | a b c. d. | * | Due to | o (or as a consec | quence of): | te | accis | 23b. Did 10 24a. Was perf | tobacco uas Yes 221 | 24b. 1 | triterval Between Onset and Death to the cause of death to the cause of death trobably 4 Unkno Were autopsy findings available prior to completion of cause of deeth? |
| To Be Completed by Physician/Medical | Sequential if any, leacause. Ecause (Dithal initial resulting) Pert II. Ott | ally list condition deeth) ally list conding to inner under under listense or red events in death) I her significant asserted to the conding to the conding to inner significant asserted to the condition of the | (Final on ditions, neediate arriving Injury St. Last | titions continued in the continued in th | ospital: 1 □ | Due to Due to Due to | o (or as a consect or | quence of): quence of): quence of): anderlying cause of 28c. i | Other | on in Part I. 26. Plece of Deet 27. 4 Nursing Ho | 23b. Did 10 24a. Was perfi | tobacco uses Yes 2 2 10 10 s an autopsy ormed? Yes 2 10 10 one) idence 8 □ | 24b. 1 | triterval Between Onset and Death to the cause of death trobably 4 Unknow Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No |
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ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienen Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year JAN 20 2000 22 ISHB NORMAN FREDERICK SULLIVAN 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE AGNES HOSPITAL BALTIMORE CITY ST If Under 1 Year | If Under 24 Hrs. | 9. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Days Months Hours 180 M 2□ F Yrs VIRGINIA 216-09-2387 FEBRUARY 24,1914 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 N Yes 2 No MARYLAND | BALTIMORE CITY BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1362 TOWSON STREET 21230 UNITED STATES 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: 3 ☑ Widowed 4 ☐ Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SHIPYARD 12 WELDER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) FREDERICK CHARLES SULLIVAN ALICE HUMES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1807 LANSING ROAD, GLEN BURNIE, MARYLAND 21060 LILLIAN JANE McDERMOTT-NIECE 20b. Place of Disposition (Name of cemetery, cremetery or other place) 20c. Location - City or Town, Stata 20s Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1-27-00 BALTIMORE, MARYLAND LOUDON PARK CEMETERY 21. Signature of Funetal Service Licens 22. Name and Address of Facility LOUDON PARK FUNERAL HOME 3620 WILKENS AVENUE, BALTIMORE, MARYLAND 21229 23a. Part. Enfet the disease, or commications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. Approximate tntervel Between Onset and Death SEPSIS Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) DNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 | Yes 2 | No 3 | Probably 4 Unknown SEVERE TRICUSPID REGURGITATION 24b. Were autopsy tindings available prior to completion of cause of death? PULMONARY ITY PERTENSION 24a. Was an autopsy performed? SEVERE 1 Yes 2 XNo 25. Was case referred to medical axaminer? 26. Place of Deeth (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 ☐ Could not be determined 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, lactory, office building, etc. (Specify) 4 Homicide

/Medical Examiner pue physician s the buriel signed by t of Vitai Records, NORMAR

Physician/Medical þ Completed e edical Certification: To this After I or Attending i efter death. efter death. Director: After d in by the fun

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or items 23s or 25s-f show the Medical Examinar must be notified at

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pernit. Pages 1 and 2 should be filed Department of Heelth and Mantel Hygic Important: If Item 27 is marked other: eny Injury or other treumatic event.

Physician

Saitimore, Maryland 21215-0020

To the Hospital or within 24 hours eft To the Funeral Di completely filled in

Division

State

31. Date filed (Month, Day, Year)

29a. Certifier

29b. Signature and title of certifier M. 29c. License number P13601

i Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 20/2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

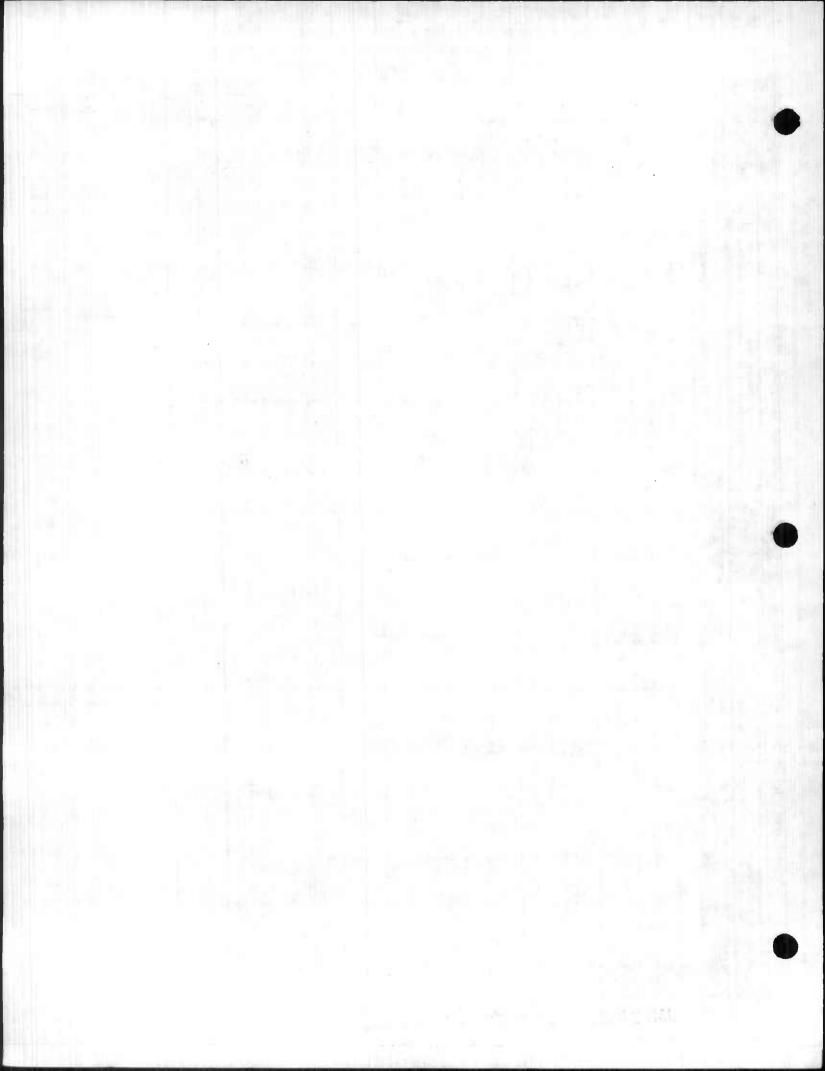
CEASAR; 2506 WEST PATAPSTO AVENUE APT 30 BALTIMORE ND 21230

22 Registrar's Signature MAN 2 @ 2000

ORIGINAL

Registrar **DHMH 16 Rev 6/95**

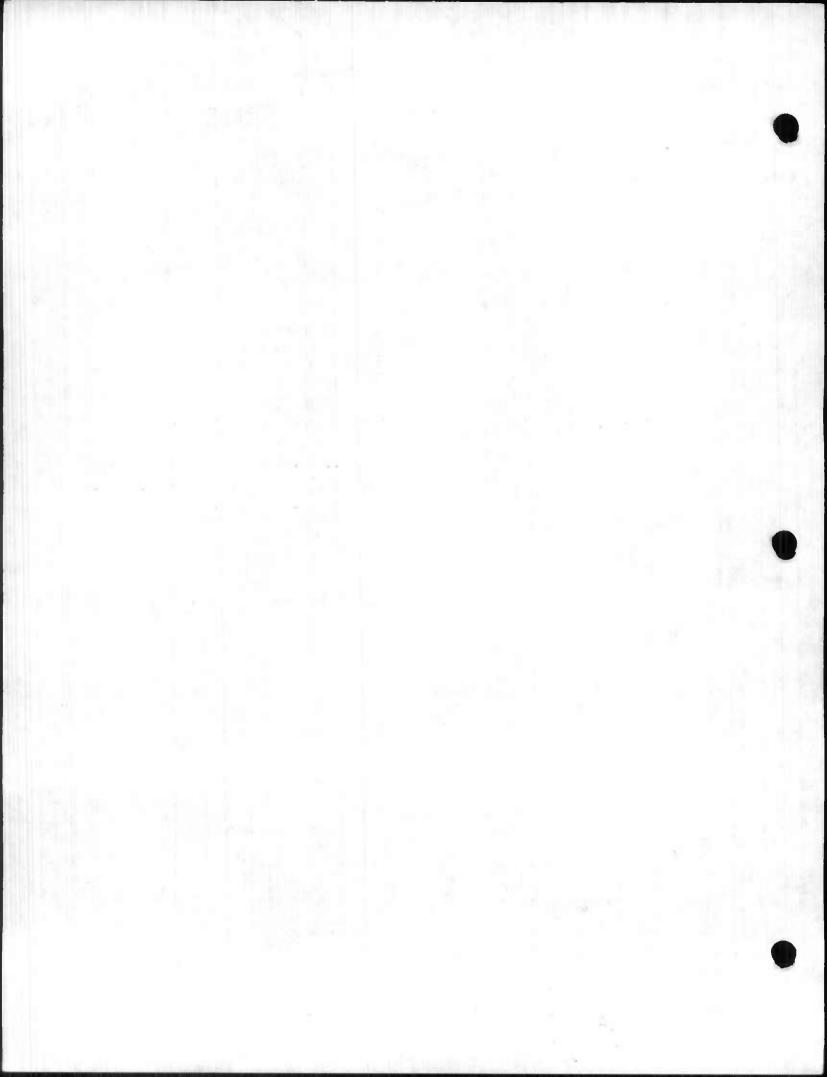
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death **Physician** 2080 2225 VANUARY 25 Phyllis McNabb Shannon /Medical 4b. City, Town, or Location of Dyath 4a Facility Nama (If not institution, give street and number) 4c. County of Death **Examiner** Fallston Harford Fallston General Hospital If Under 24 Hrs. If Under 1 Year 8. Data of Birth (Month, Day, Year) June 29, 192 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Days Months 1 M 2 XF Yrs. 212-28-1956 Director MD. Usual Residence of Decedent the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show 1 Yes 2 No Director MD. Harrford Forest Hill SHANNON 10e. Sireet and Number 10g. Citizen of What Country? 10f. Zio Code Nerns 23a 110 F Gwen Drive 21050 Funeral USA 12. Was Decedent Ever in U,S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Meritai Stetus 1 ☐ Yes 2 💢 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 8 Baltimore, Maryland 21215-0020 1 Yes 2√ No Specify: Specify: 3 Widowed 4 Divorced White permit. Pages 1 and 2 should be filed within 72 hs. Department of Health and Merial Hyglene. Important: If item 27 is marked other than "neture any injury or other traumatic event, the Medical abose. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Eiamentary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Samuel McNabb Mabel Reeder 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard E. Shannon (son) 2120 Bellvale Rd. Fallston, MD. 21047 20b. Place of Disposition (Name of cemetary, crematory or other place) 20a. Method of Disposition Data 20c. Location - City or Town, State ₩X Buriat 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Mem. Grdns. 01/29/2000 Timonium, MD. 21. Separature of Funeral Service Hoonsee Parinis C. Carrol-22. Nama and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, MD. 21204 23a Fact Enter the disaasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediata Causa (Final disease or condition resulting in death) Overwhelming days Examiner Due to (or as a consequence of): Physician/Medical Examiner disease lung sician and burial-transit hermontic ceors The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Diseese or injury that initiated events resulting in death) Last Dua to (or as a consequence of Box 68760, physician s the burial Cteraig havced Marsong or animal en Dua to (or as a consequence of): 40 enal P.O. Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Xves 2 No 3 Probably 4 Unknown (chonon's onter disports Records. by been signe should be 24b. Were autopsy lindings available prior to completion of cause of death? Be Completed 24a. Was an autopsy performed? Diabetes mellitus page 2 2 No 1 Yas 1 ☐ Yes 2 ☐ No certificate of Vital or Attending Physician: funeral director, 25. Was case raferred to medical 26. Place of Death (Check only one) axeminer? Hospital: 1 Anpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) edical Certification: To this 27. Magner of Death 28a. Data of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Affer Division 1 Naturai 5 Pending 1 Yes 2 No 24 hours after death. Funeral Director: A 2 Accidani investigation the 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, Stata) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted.
2 Medical Examiner: On the bests of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) within 2 the th 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Dev. Year) MD January 2000 30. Name and addrass of person who complated cause of death (Item 23a) (Type, Print) 04 plum tree David C. Mbih Rd Bel Air 31. Data liled (Month, Day, Year) 32. Registrar's Signature State Registrar JAN 28 2000 Sports



State of Maryland / Department of Health and Mental Hygiene

| | Certificate of Death | Reg. | No. | 5030 | | | | | | |
|--|--|-------------------------------------|-------------------------|--|--|--|--|--|--|--|
| | Decedent's Name (First, Middla, Last) | 2. Date of Death Month | Day Year | 3. Time of Death | | | | | | |
| Physician /Medical | Lillian Minnie Solowski | | 22, 2000 | 7:00 PM | | | | | | |
| Examiner | 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Loc | cation of Death | 4c. County of Death | | | | | | | |
| | 344 Dogwood Road Millersvi | lle | Anne An | rundel | | | | | | |
| Funeral | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. | 8. Date of Birth (Month, Day, Ye | 9. Birth | place (Stata or Foraig | | | | | | |
| Director | 219-20-8348 1 M 2D F 99 Yrs. Months Days Hours Min. | May 11,19 | 900 Per | nsylvania | | | | | | |
| No M | 10a. State 10b. County 10c. City, Town or Location | | | 10d. Inside City Limit | | | | | | |
| Men feet for | Maryland Anne Arundel Millersvil | 10 | | 1□Yas 2≧N | | | | | | |
| vith the Ma to c 28a-f s be notified Director | Maryland Anne Arundel MillersVII 10e. Street and Number 10f. Zip Code | | Citizen of What Cou | intry? | | | | | | |
| O B O | 344 Dogwood Road 211 | 08 | United St | ates | | | | | | |
| fler death with the Maryla r items 23a or 28a-f shor siner must be notified at Funeral Director | 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specific Yes, specify Cuban, Maxican, Puarto Forces) | | 14. Race - Amer | | | | | | | |
| Fur fine | 1 Naver Married 2 Married 1 ☐ Yes 2+3-No | Ricen, etc.) | Black, Whita | , atc. | | | | | | |
| by F | #Yes, Giva 1 ☐ Yes 2 ☐ No Specify: \$\infty \text{SWidowed} 4 \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ | | Specify: | White | | | | | | |
| | 15. Decedant's Education 16a. Decedent's Usual Occupation | 168 | b. Kind of Business/i | | | | | | | |
| ed within 72 ho yglens. wer than "naturn ft, the Medical Completed | (Specify only highast grada completed) (Giva kind of work dona during most of working DO NOT use retired) | 99 | | | | | | | | |
| the the | Elementary/Secondary (0-12) College (1-4or 5+) 6 Years Homemaker | | Own Home | | | | | | | |
| | 17. Father's Name (First, Middla, Last) 18. Mother's Name | (First, Middle, Mai | | | | | | | | |
| writal H and oth and oth and oth and oth and oth and oth and oth and oth and oth and oth and oth and oth and o | Edgar Arthur Garrison Jul | ia Ann G | rav | | | | | | | |
| To To | 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural | | | in Code l | | | | | | |
| 26.50 | Lillian L. Murphy (Daughter) 344 Dogwood Road Mil | | | | | | | | | |
| s 1 and f Health lam 27 other to | 20a Method of Disposition 20b. Place of Disposition (Nama of | | c. Location - City or 1 | | | | | | | |
| 0 11 0 | 1 ⊠ Burial 2 □ Cremation 3 □ Ramoval from State cematary, cramatory or other place) | | | | | | | | | |
| L. Page tment of tant if flary or | 4 Donation 5 Other (Specify) First United Evan.Cem. 1/28 | /00 I | Baltimore, | Maryland | | | | | | |
| 100 400 | 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral He | ome of Di | ındalk. Tr | nc. | | | | | | |
| 22528 | Johnny L. Stee Duda-Ruck Funeral Ho | | | L222 | | | | | | |
| | 23a. Part1. Enter the diseasa, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or shock, or heart failure. List only one cause on each lina. | respiratory arrast | Lylana 2 | Approximata | | | | | | |
| hysician . | | | i | Intarval Between Onset and Death | | | | | | |
| /Medical | Immediata Cause (Final | | | Seva I year | | | | | | |
| Examiner | Immediata Cause (Final disaasa or condition rasulting In death) a Con rest. ve heart for large from the consequence of the con | | | A1140 414 | | | | | | |
| - E | Due to (or as a consequence of): | | - | 1 | | | | | | |
| neate be executed physician and s the burst-transit edical Examiner | b | | 1 | | | | | | | |
| icate be assocuted physician and street transit street buriel-transit edical Examir | Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury c. that initiated events Due to (or as a consequence of): | | | | | | | | | |
| buri buri | Cause, Entar Underrying Cause (Disaase or injury the initiated greats | | 1 | | | | | | | |
| og physi as the | resulting In death) Last Due to (or as a consequence of): | | | | | | | | | |
| 5 0 0 | | | | | | | | | | |
| death cert e attendin d for use sician/N | | | | | | | | | | |
| ysi hed | Part II. Other significant conditions contributing to death but not resulting in the underlying cause givan in Part I. | 23b. Did toba | eco una contributa | to the cause of deal | | | | | | |
| ed by detac | | 1 Yes | 2 □ No 3 □ Pr | obably 4 Unknow | | | | | | |
| 2 88 2 | | | 1 | A - Color - Co | | | | | | |
| the law requires tate has been sign. page 2 should be Completed by | | 24a. Was an a performe | d? | Vere autopsy finding | | | | | | |
| 8 K | | | | completion of causa of death? | | | | | | |
| page page | | 1 □ Yas | 2 2No | ☐Yes 2☐No | | | | | | |
| s certificate hes t director, page 2 s | 25. Was cese referred to medicel 26. Place of Death | (Check only ona) | | | | | | | | |
| nis certificate he il director, page | examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Hon | 1/ | ce 8 Other (Spec | eifu) | | | | | | |
| r this certific eral director. | 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 2 | 8d. Describe how | | , | | | | | | |
| Amending in death. ector: After by the fune fillcation. | Natural 5 Pending (Month, Day Year) Injury Work? 2 Accident investigation M 1 Yes 2 No | | | | | | | | | |
| rs after death. al Director: After to led in by the funera Certification: | 3 Sulcide 6 Could not be 28e, Place of Injury - At home, farm, street, factory, office 2 | 81. Location (Street | et and Number or Ru | ral Routa Number, | | | | | | |
| Pin Direction | 4 ☐ Homicide building, atc. (Specify) | City or Town, S | Stata) | | | | | | | |
| within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di Medical Certification: To | 29a. Certifier Tecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, a | nd due to the caus | ea/e) and manner as | etated | | | | | | |
| in 24 hour he Funer pletely fill edical | (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurre and manner stated. | ed at the time, date | and place, and due | to tha ceuse(s) | | | | | | |
| Me app | 29b. Signature and title of certifier 2 29c. Licensa number | 294 | . Date signed (Monti | Day Year) | | | | | | |
| 378 | January I Day 521133 | , | 104/2 | | | | | | | |
| (), | | | 124/200 | 0 | | | | | | |
| OI B | 30. Name and address of person who completed ceuse of death (Itam 23a) (Type, Print) | 2-14. M | 0 3.22 | | | | | | | |
| ed, | Jose Zarquele M.D., 323 N. Colvert St. C | 74, 6.3 | 3150. | - | | | | | | |
| [®] State | 31. Date filed (Month, Day, Year) 32. Registrar's Signature | | | | | | | | | |
| Registrar | JAN 2 8 2000 Deneva & Sparks | | | | | | | | | |

DHMH 16 Ray 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Date of Death 3. Time of Death Month Elizabeth Smith 21, 2000 January 10:45 am 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Genesis Eldercare Heritage Center Dundalk Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1□M 2☑F 219-38-8836 23,1915 West Virginia Usual Residance of Decedent 10a. Steta 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Baltimore Dundalk 1 ☐ Yes 2 ☑ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1904 Ormand Road 21222 United States 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yas 2 No If Yas, Giva Year or Dates: 1 Nevar Married 2 Married 1 ☐ Yes 2 ☐XNo Specify: White Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 8 Years Homemaker Own Home 17. Father's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumama) Irving Wineholt Edith Irene Mitchell 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7869 Charlesmont Road Dundalk, Maryland Mrs. Barbara A. Ratsch (Daughter) 20b. Place of Disposition (Nama of 20a. Method of Disposition Date 20c. Location - City or Town, Stata etary, crematory or other place) 1 ☑ Burial 2 ☐ Crametion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Othar (Specify) Bel Air Memorial Gdns. 1/27/2000 Bel Air, Maryland 21. Signature of Furney Sarvice Moensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediata Causa (Final disaasa or condition rasulting in daath) Sequentially llst conditions, if any, leading to immadiate cause. Entar Underlying Cause (Disaase or Injury that initieted evants rasulting in death) Last Dua to (or as a consequence of): Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 100 1 Yes 2 No 25. Was case referred to midical 26. Place of Death (Check only one) axaminer' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 27. Mannas of Death 28b. Tima of 28d. Describe how injury occurred

Box 68760 P.O. Records, 200 certificate Division of Vitai or Attending Physician; this funeral Affer 24 hours after death.

Examiner Physician/Medical þ Be Completed Medical Certification: To

Physician

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Funeral

Director

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Department of Health a important: If Hem 27 is any injury or other trau

Physician /Medical

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altimore, Maryland 21215-0020

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Pages 1 and 2 should be nent of Health and Mental

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Funeral

Completed

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1 PNeturel

2 Accidant 3 Suicida 4 Homicide

(Check only one)

29a. Certifier

6 Could not be determine

28a. Data of Injury (Month, Day Year) 5 Panding invastigation

26e. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify)

28c. Injury at Work? 1 Yes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signeture and titla of certifia? L'COM.

29c. License number 008358 30. Nama and address of person who completed cause of death (Item 23a) (Type, Print) 8403 (44 ETORD POLICE

29d. Data signed (Month, Day, Year)

RACIG 31. Data filed (Month, Day, Year)

32. Registrar's Signatura JAN 2 8 2000

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State Registrar

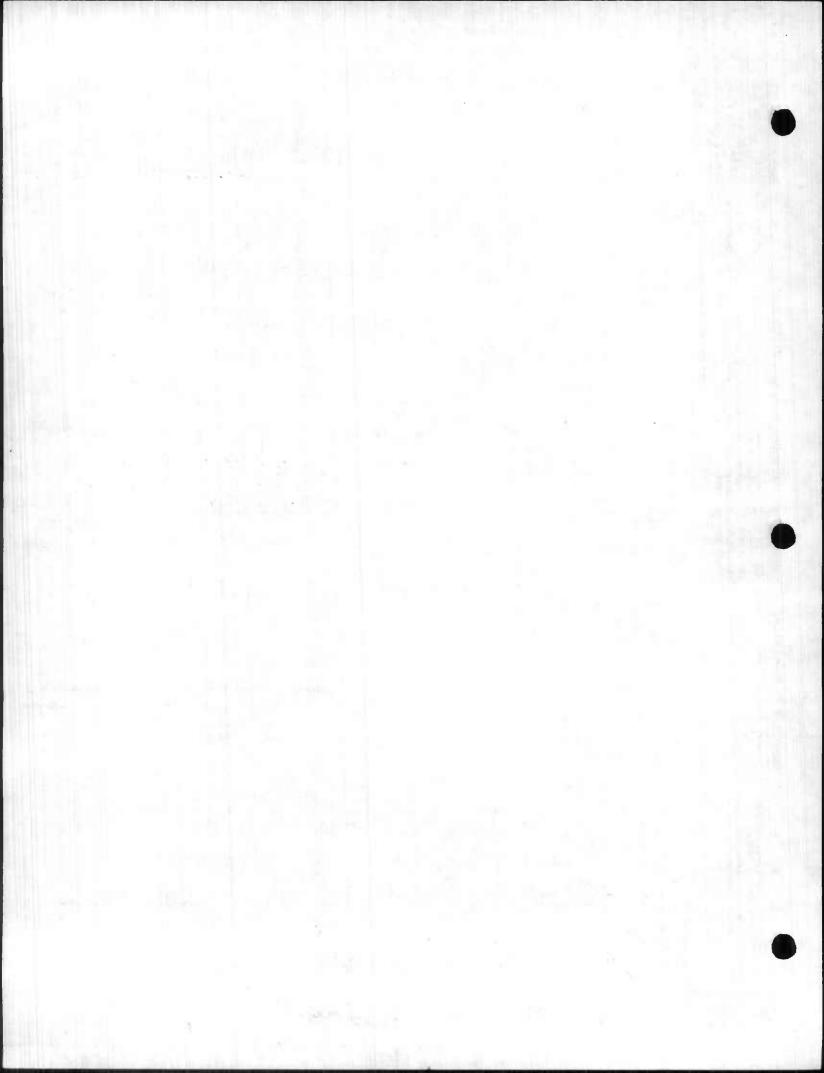
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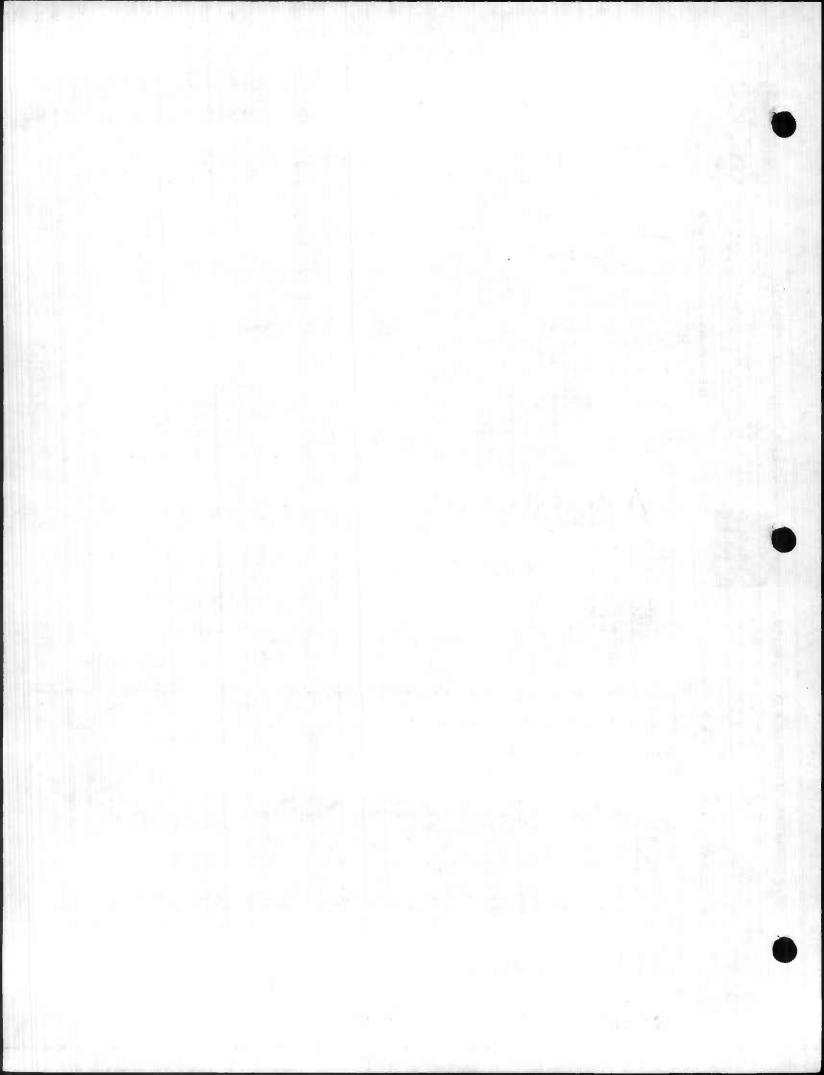
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| ANNA ALICE SCHADEL 4a Facility Name (If not institution, give street and number) 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth 4c. County of | Physician /Medical Examiner ANNA ALICE SCHADEL 4a Facility Name (If not institution, give street and number) Frankin Square Hospital Center Rose 6 Schlodin Anna ALICE SCHADEL | 2. Dete of De Month | ath Dey | fear |
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| SOWGood of Cloversed Value Tortes: Time 20% Speech: Speech: White Speech: | 606 Maryland Ave. 21221 | | | |
| SOM/Gowed & Ciphorocad Teac Orbest 10 Decedent Space(): Whitte Specify: | 11. Marital Status 12. Wes Decedent Evar in U.S. 13. Was Decedent of Hispanic Origin? | ? (Specify Yes or No | | American Indian, |
| SOM/dowed 4 Divarced 1 1 1 1 1 1 1 1 1 | | uerto Rican, atc.) | Black, | |
| 17 Father's Name (First, Modes, Leat) 18. Mother's Name (First, Modes, Leat) 190. Melling Address (Street and Number or Pural Route Name) 190. Melli | | | Specify: | White |
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| DR Haris Aleem 4000 Franklin Square Drive Baltimore Maryland 21237 | D47943 | | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) | | | |

Schadel, Anna



Please Type or Print in Black Indelible Ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Date of Death 3. Tima of Death Month ANNE STAHM M JANUARY 21.2000 06:20PM 4c. County of Death 4a Facility Name (If not institution, give street and number) 4h. City. Town, or Location of Death Saint Joseph Medical Center Towson Baltimore If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Dey, Year) July 20 1940 5. Social Security Number 7. Age (In yrs. last birthday) Birthplaca (Stete or Foreign Country) Days Months 1□M 20 F 59 220-36-6352 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits PA Bedford Bedford 1 ☐ Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 653 Cherry Run Road 15522 USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14, Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Self-employed Dog Grooming 2 yrs 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middla, Meiden Sumama) John Cushing Marie Haberkam 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Stephen Stahm / husband 653 Cherry Run Road Bedford PA. 20b. Place of Disposition (Nema of 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☑ Cramation 3 ☐ Removal from State 1/25/2000 Metro Crematory Inc. Baltimore Md. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funaral Sarvice License 22. Name and Address of Facility Connelly Funeral Home of Essex na that caused the death Do not enter the mode of dying, such as caldied of respiratory arest, Md. 21221 23a Part1. Enter the disease, or con shock, or heart failure. List only Approximate triterval Between Onset and Deeth Immediate Cause (Final CEREBRØ VASCULAR ACCIDENT 1 WEEK disease or condition resulting in death) Due to (or as a consequenca of): ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequenca of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown SEPSIS 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy RENAL FAILURE 1 ☐ Yas 25. Was case referred to medical examiner? 26. Placa of Death (Check only one) Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 27. Manner of Deeth 28d. Describe how injury occurred 28a. Date of Injury (Month, Dey Year) 28b. Time of Natural 5 Pending 1 Yas 2 No 2 ☐ Accident invastigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homleide Certifying Physicien: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated. | Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

Examiner ician and burial-transit requires that the death certificate be assecuted physician s the burial P.O. Box 68760. Physician/Medicai 3 bengis be ed b Records, þ Completed The law page 2 Division of Vital or Attending Physicien: Be Medicai Certification: To this After

death. 24 hours after deat Funeral Director: filled in by

Physician

/Medical

Examiner

Funeral

Director

WOUG

28e-f

Nema 23a or

Examiner must be notified at

Director

Funeral

p

Completed

Be 2

with the Maryland

death v

permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If New 27 ie marked other than "natural" any injury or other traumatic excessions.

Physician /Medical

Examiner

within 2 \$ 0

DHMH 16 Rsv 6/95

Hospital

31. Date filed (Month, Dey, Year) State Registrar

FRANCIS KHOO,

29b. Signature and title of certifier

(Check only one)

32. Registrar's Signature

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

M. D.,

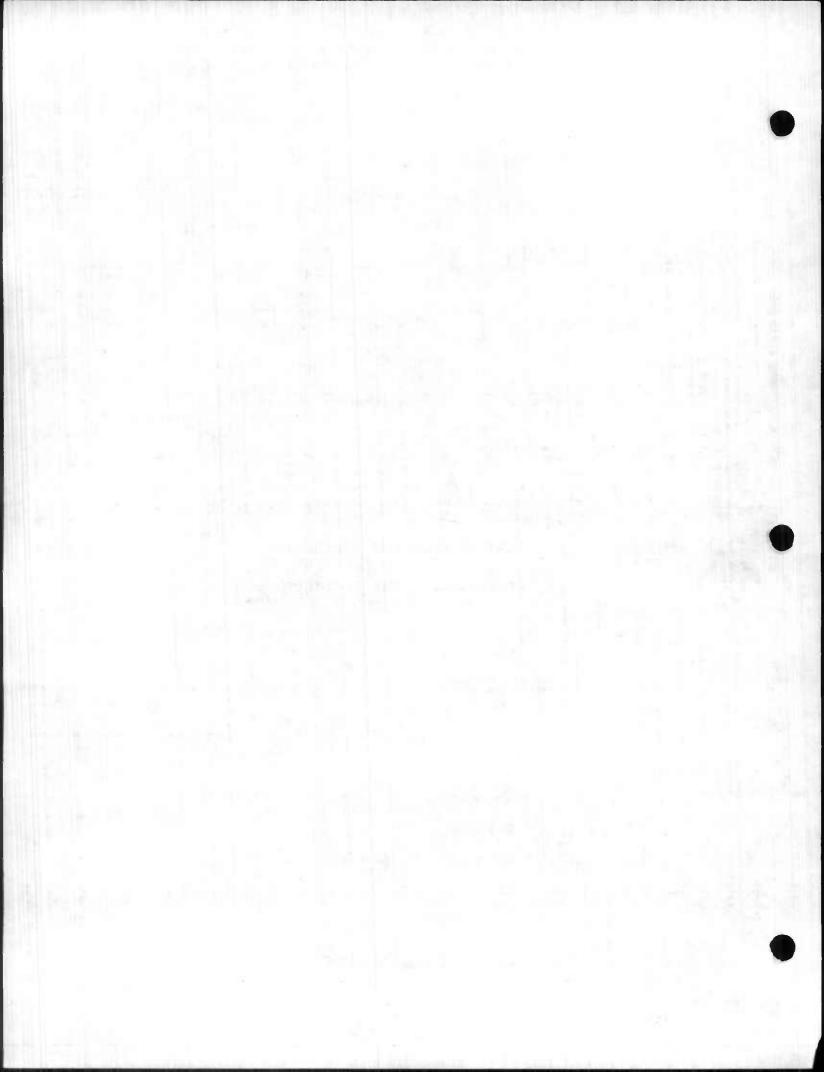
ORIGINAL

29d. Date signed (Month, Day, Year)

D 30263

7601 OSLER DRIVE TOWSON, MARYLAND 21204

29c. License number



| | AMEND II | STMMS EMS: #23 PART I, 2 | 27, 28A-F PER M | IEO CE | ertificate of | Health and I Death | | leg. No. | | 3. Tims of Death |
|-----------------------------------|---|--|--|--|--|--|--|---|---|--|
| r _{ip} | Physician /Medical | SYLVESTER EDWA | | | | | JAN. | 22, 200 | | 9:11 PM |
| 1 | Examiner | 4a Facility Name (If not institution, g SINAI HOSPITA | | | | 4b. City, Town, or I BALTIMO | | 4c. County | y of Death [MORE (| CITY |
| | Funeral Director | 215-46-5572 | Sex 1⊠ M 2□ F 7. Age (In yrs. 54 | last birthday Yrs. | Months Days | | 8. Date of Birth (Month, Day January | Year) | 9. Birthpla | ca (Stata or Foraign |
| | ter death with the Maryland Herrs 23a or 28a-f show Inst. must be notified at Funeral Director | Usual Residence of Decedent 10a. State 10b. County | | 10c. City, Town or Location Baltimore | | | | | 100 | l. Insida City Limits |
| | or 28a-f a be notified Director | Maryland Baltimo | | e CITY BAILTINGTE 10f. Zip Code | | | | 0g. Citizen of | What Country | y? |
| | ath w | 5502 Cadillac Av | enue | nue 21207 | | | | United | | |
| 70 | 5 5 E | | If Yes, Give | J,S. 13. | . Was Decedent of If Yas, specify Cu 1 ☐ Yes 2 ☑ No | Hispanic Origin? (S ban, Maxican, Puert Specify: | pecify Yas or No- o Rican, etc.) | Bla | 14. Race - American India Black, White, etc. Specify: Blac | |
| 3 | hours, o | 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's | Year or Datas: | 16a Dec | edent's Usual Occi | ination | | 16b. Kind of B | | |
| 21215-0020 | than the Mo | (Specify only highest of Elementary/Secondary (0-12) | | (Giv life. | e kind of work don DO NOT use retir | e during most of wor ed) | king | Educat | | Sity |
| 2 | Hygie other is ent. It | 17. Father's Name (First, Middle, La | • | beno | or reach | 1 | ne (First, Middle, | | | |
| Maryland | Mental Mental arked o affic eve | James Simms Viola Allen | | | | | | | | |
| lar) | and h | 19a. Informant'a Name/Relationship | (Type, Print) | 19b. Mai | ling Address (Street | et and Number or Ru | rai Route Numbe | r, City or Town | , State, Zip C | Code) |
| Baltimore, | Department Important any Injury | 21. Signature of Fundral Sarvice Lic | | L | ark Cemet 22. Nama and Add oudon Pa | ress of Facility | 1-28-00 1 | | | |
| | Physician /Medical | 23a. Parti. Enfer the disease, or of shock, or heart failure. List of Immediate Cause (Final | | th. Do not er | 620 Wilkenter the mode of dy | ens Avenue ying, such as cerdiac | e, Balti; or respiratory and | rest, | - 6 | ond 21229 Approximate Interval Between Onset and Death |
| | /Medical Examiner | Immediate Cause (Final disease or condition resulting in death) | ATHERO | th. Do not er | 620 Wilkenter the mode of de | ens Avenue | e, Balti; or respiratory and | rest, | - 6 | Approximate interval Between |
| ou, | /Medical Examiner Examiner | Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | aATHERO | th. Do not er | 620 Wilkenter the mode of district CARD squence of): | ens Avenue ying, such as cerdiac | e, Balti; or respiratory and | rest, | - 6 | Approximate interval Between |
| 5x 68/60, | /Medical Examiner Examiner | Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | aATHERO bDue to (| SCLERC | 620 Wilkenter the mode of dispersion of the mode | ens Avenue ying, such as cerdiac | e, Balti; or respiratory and | rest, | - 6 | Approximate interval Between |
| BOX. | the death certificate be executed with the attending physician and ached for use as the bunial-transit ached for use as the bunial-transit hysician/Medical Examiner | Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | aATHERO a | SCLERC or as a conse or as a conse or as a conse | 620 Wilkenter the mode of district the mode of district CARD equence of): | ens Avenue ving, such as cerdiac IOVASCULA | R DISEAS | est, | ontributs to t | oproximate interval Between onset and Death onset and Death |
| P.O. BOX | the death certificate be executed the attending physician and letached for use as the burial-transit the physician/Medical Examiner | Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | aATHERO a | SCLERC or as a conse or as a conse or as a conse | 620 Wilkenter the mode of district the mode of district CARD equence of): | ens Avenue ving, such as cerdiac IOVASCULA | R DISEAS | pobecco uss co yes 2 No | ontributs to t 3 Probe 24b. Were available com | the cause of death which is a subject to the cause of death and Death which is a subject to the cause of death and D |
| necords, P.O. box | The law requires that the death certificate be executed at the has been signed by the attending physician and page 2 should be detached for use as the burial-transit completed by Physician/Medical Examiner | Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | aATHERO a | SCLERC or as a conse or as a conse or as a conse | 620 Wilkenter the mode of district the mode of district CARD equence of): | ens Avenue ving, such as cerdiac IOVASCULA | R DISEAS 23b. Did to | obacco usa co /ss 2 No | ontributs to t 3 Proba 24b. Werravair com of de | oproximate interval Between onset and Death onset and Death on the cause of death of the cause of death on the cause of death of death on the cause of dea |
| necords, P.O. box | The law requires that the death certificate be executed at the has been signed by the attending physician and page 2 should be detached for use as the burial-transit completed by Physician/Medical Examiner | Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Part II. Other significant conditions 25. Was cese referred to medical axaminer? | ATHERO a. Due to (c. Due to (d. Contributing to death but not received) | SCLERC or as a conse or as a conse or as a conse | 620 Wilke the mode of dy STIC CARD squence of): equence of): underlying ceuse of | ens Avenue ving, such as cerdiac IOVASCULA given in Part I. | 23b. Did to 100 | pobacco usa co 'ss 2 No an autopsy med? | ontributs to t 3 Proba 24b. Werravair com of de | coproximate interval Between onset and Death onset and Death of the cause of death obly 4 Ponknow e autopsy findings lable prior to plation of cause seath? |
| of Vital Records, P.O. Box 68760, | hystolan: The law requires that the death certificate be executed the certificate has been signed by the attending physician and all director, page 2 should be detached for use as the burial-transit. To Be Completed by Physician/Medical Examiner. | Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Part II. Other significant conditions 25. Was cese referred to medical axaminer? | ATHERO a. Due to (b. Due to (c. Due to (d. Contributing to death but not received a light of the contribution of the co | th. Do not en | 620 Wilkenter the mode of dy VTIC CARD equence of): equence of): underlying ceuse of | ens Avenue ving, such as cerdiac IOVASCULA Diven in Part I. | 23b. Did to 10 Yearth (Check only on 10 Yearth | obacco usa co 'sa 2 No an autopsy med? res 2 No ne) ence 6 Ott | 24b. Wer avail composed to the (Specify) | che cause of death which the cause of death ably 4 2 nknow e autopsy findings lable prior to plation of cause path? Yes 2 No |
| Vital Records, P.O. Box | Itelan: The law requires that the death certificate be executed certificate has been signed by the attending physician and rector, page 2 should be detached for use as the builat-transit and be Completed by Physician/Medical Examiner | Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Part II. Other significant conditions 25. Was cese referred to medical axaminer? | ATHERO a. Due to (b. Due to (c. Due to (d. Contributing to death but not resonant to the contribution of the contributi | th. Do not en | 620 Wilkenter the mode of dy OTIC CARD equence of): equence of): underlying ceuse of the content | ens Avenue ving, such as cerdiac IOVASCULA Diven in Part I. | 23b. Did to 10 Yeath (Check only on the control of | obacco usa co 'sa 2 No an autopsy med? res 2 No ne) ence 6 Ott | 24b. Wer avail composed to the (Specify) | che cause of death which the cause of death ably 4 2 nknow e autopsy findings lable prior to plation of cause path? Yes 2 No |

State Registrar

JAN 2 8 2000

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

31. Dafa filed (Month, Day, Year)

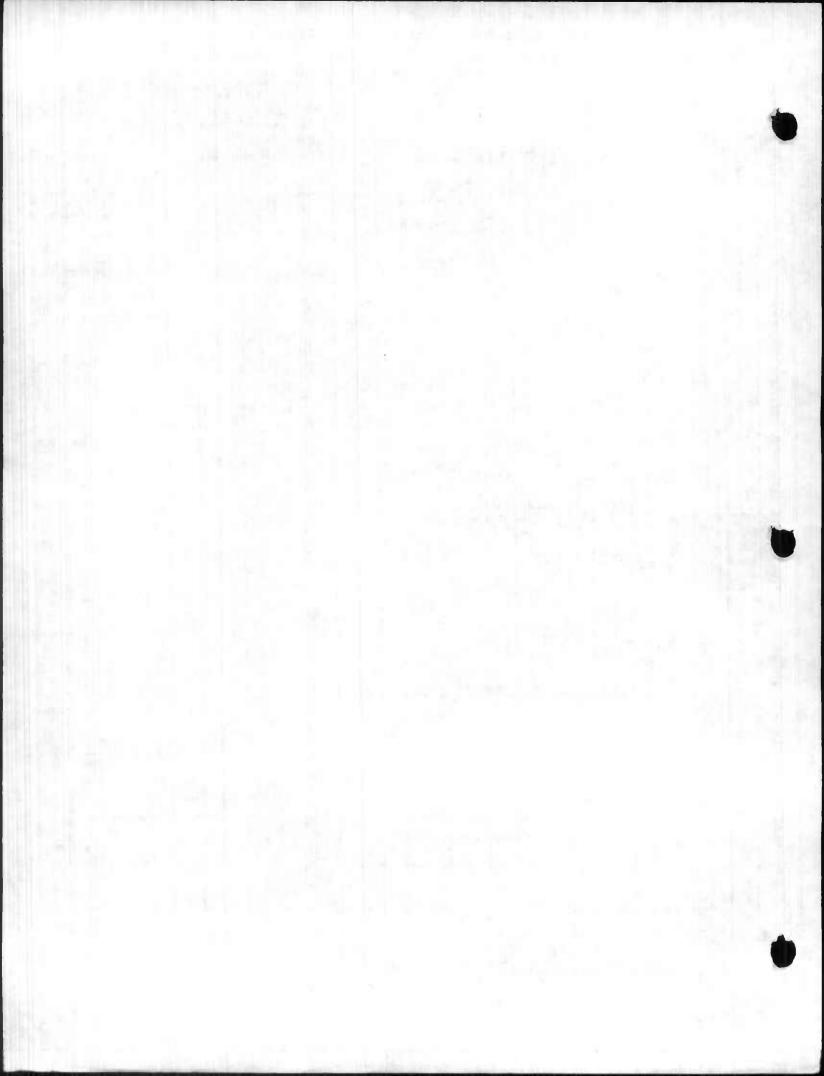
32. Registrar's Signature

29c. License number

O.C.M.E

29d. Date signed (Month, Day, Year)

JAN. 23, 2000



Examiner Box 68760 P.O. Division of Vital Records. To the Hospital or Attending Physicien: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director,

Physician

/Medical

Examiner

Funeral

Director

r 28a-f show

permit. Peges 1 and 2 should be filed within 72 hours after death with Department of Heelih and Mental Hybjane.

The mortant if flow 27 is marked other than "natural", or flows 23a or in any injury or other traumatic event, its Maries Examine mainteer.

Physician /Medical

burial-transit

and physician street

certificate

Baltimore, Maryland 21215-0020

Director

Funeral

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Completed

Be

Examiner

Physician/Medical

A

Completed

Be

Certification: To

Medical

the Maryland

Registrar

31. Date filed (Month, Day, Year) JAN 2 8 2000

29b. Signeture end title of certifier

32. Registrar's Signature

RESIDENT

PHYSICIAN



29c. License number

P10290

29d. Date signed (Month, Day, Year)

JAMARY 19,00

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month Lillian Sumik 01 2000 11:40 PM 4c. County of Death 4s Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Heritage Nursing Center Baltimore Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Hours 1 M 2 F Days 96 213-10-3581 10-27-03 MD Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. tnslde City Limits 1 ☐ Yes 2 ☐ No Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7232 German Hill Road 21222 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11 Marital Status Black, White, etc. 1 Never Married 2 Married Specify: White 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Malden Sumane) Meat Cutter 17. Father's Name (First, Middle, Last) Anthony Sumik Helena Chojnacki 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mrs. Mary Kosiba - Niece 2515 Boston Avenue, #305, Balto., MD 21224 20e. Method of Disposition 20b. Plece of Disposition (Name of Date 20c. Location - City or Town, State St. Stanisland Burlai 2 Cremetion 3 Removal from State 01 - 26Balto., MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service License Kaczorowski F. H. 1201 Dundalk Avenue, Baltimore, MD 21222 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart feilure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final osselle Acute MI disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Chelon Part It, Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco usa contribute to the causa of death? 1 ☐ Yaa 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy lindings available prior to completion of cause of death? 24e. Was an autopsy performed? 1 Yas 2 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 28a. Date of tnjury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work?

Examiner bunial-transit Box 68760. physician the Records, P.O. Division of Vital 24 hours after death. Funeral Director: After or Attending

Physician

/Medical

Examiner

Director

Funeral

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Completed

6

Funeral

Director

the Maryland

permit. Pages 1 and 2 should be filed within 72 hours efter deeth with the Manylan Department of Health end Mental Hyglena. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic svent, the Medical Examiner must be notified at

Physician /Medical

Examiner

Physician/Medical

þ

Completed

Be

2

Certification:

Medical

Saltimore, Maryland 21215-0020

1 Matural

29e. Certifier

25. Was case referred to medical axaminer? 1 Yes 2 No 27. Manner of Death

> 5 Panding investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 4 Homicide

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signeture and title of certifier

29c. License number 421/ 29d. Date signed (Month, Day, Year) 1,24,2000

30. Name and address of person who completed cause of death (ttem 23a) (Type, Print) Bulling 221

1. A. 31. Dete filed (Month, Day, Year)

JAN 2 8 2000

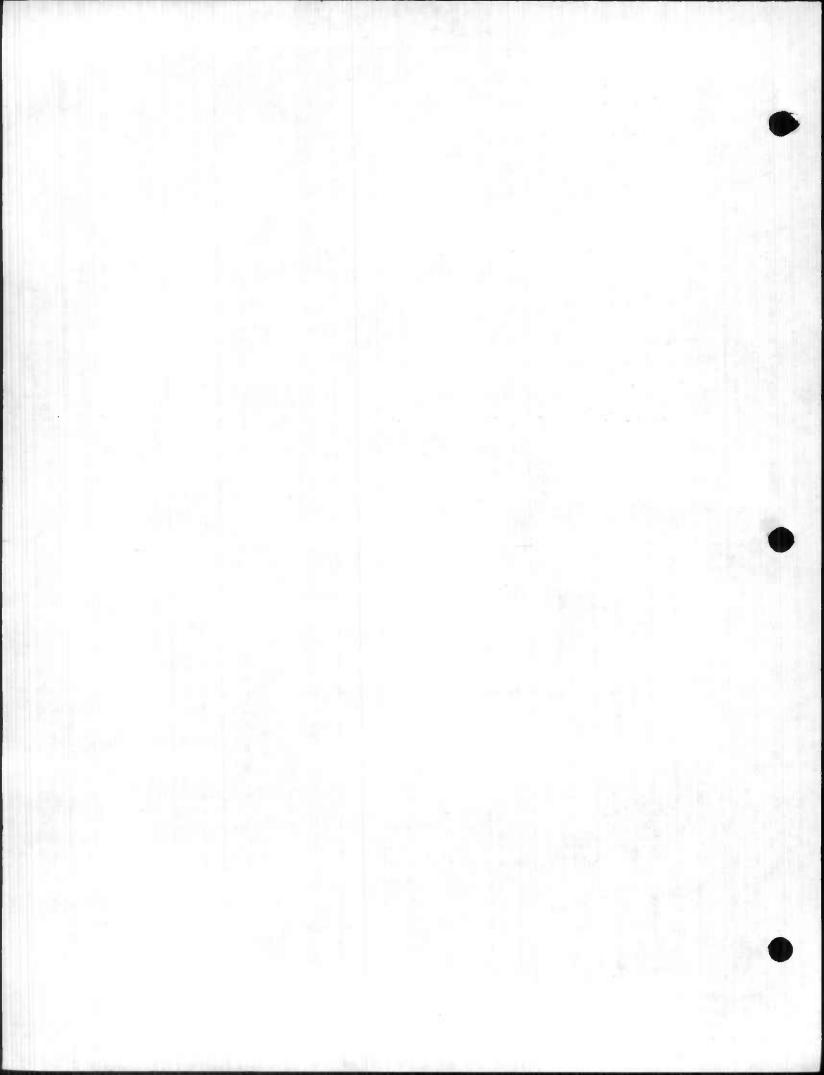
32, Registrar's Signatura

Perce des 42mg

Registrar

Hospital

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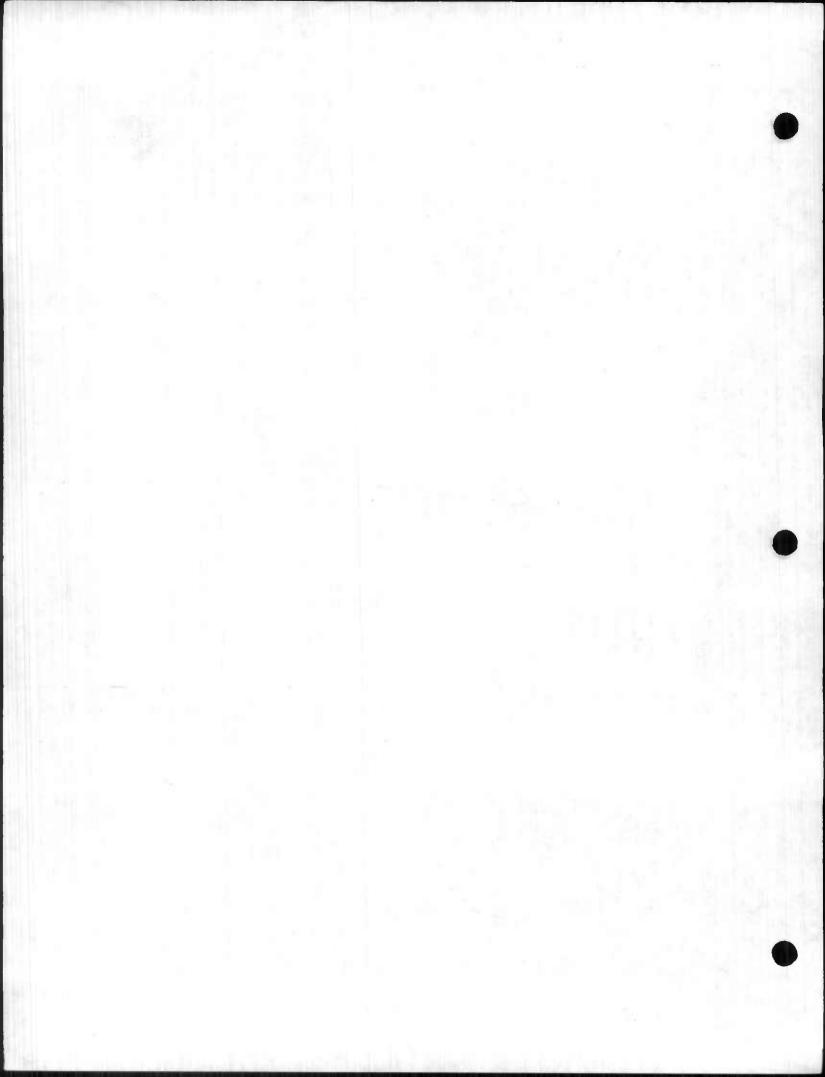
State of Maryland / Department of Health and Mental Hygiene U AMEND: ITEM; #20A PER F.H. G779 1-28-2000 WR. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dale of Death 3. Time of Death Month Day Yeer JANUARY 20, 2000 **Physician** MARTE SKINNER 4:30 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PIKESVILLE NURSING BALTIMORE BALTIMORE 5. Social Security Number , 212–30–3020 If Under 1 Year | If Under 24 Hrs. 8. Dale of Birth (Month, Day, Year) FEB.1,1908 7. Age (In yrs. lest birthdey) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 10M 201F 91 Yrs. AUSTRIA Director Usual Residence of Decedent 10a Stele 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23s or 28s-f show r than "natural", or items 23a or 26a-f sho the Medical Examiner must be notified at MD 1 No Yes 2 □ No N/A BALTIMORE Director 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 2500 W. BELVEDERE AVENUE #808 21215 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, Black, White, etc. 11. Marital Status 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1□Yes 2No Maryland 21215-0020 Specify þ WHITE 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16s. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry filled within Elementary/Secondery (0-12) College (1-4or 5+) Hygiene. FUR FINISHER FURRIER 17. Falher's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be should be find Mental 9 is marked **EDWARD** DEUTSCH HERMINE ROBICEK 10 19a. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) important of Health at Important if Hem 27 is n any Injury or other to Mics. 9402 SLOW RAIN WAY - COLUMBIA, MD 21046 ED DEUTSCH / NEPHEW Baltimore, 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State T Surlat 2 ☐ Cremation. 3 ☐ Removal from State DRUID RIDGE MEMORIAL PARK 1/23/00 4 ☐ Donallon S(IX) Other (Specify) MAUSOL EUM BALTIMORE, MD 21. Signature of Funeral Service Licenses 22. Name end Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Deeth **Physician** ARDIONASCULAR /Medical Immediate Cause (Finel disease or condition resulting in death) THERD SCLEROTIC Examiner Due to (or es a consequença of) Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initialed eventa resulting in death) Last Due to (or as a consequence of): **Bud** Box 68760. ed by the attending physician detached for use as the buria Physician/Medical Due to (or es a consequença of) P.O. Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contributa to the cause of death? ate has been signed by page 2 should be detac 1 Yaa 2 No 3 Probably 4 Onknown Division of Vital Records. þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy bemorhed' this certificate has 1 ☐ Yes 20 No 1 Yes 2 No Physician: Be 25. Wes case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) 10 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Dete of Injury (Month, Dey Year) 27. Menner of Death 28b. Time of Injury et Work? 28d. Describe how injury occurred Certification: al or Attending P after death.

I Director: After to in by the funera Natural 5 Pending Investigation Injury 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined 281. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - Al home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 Homlcide To the Hospital ewithin 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated.

| Medicat Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) end manner stated. Medical 29a. Certifier (Check only one) 29b. Signeture and title of certifier 29d. Date signed (Month, Dey, Year) 29c. License number 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HEIGHTS TASNEEM ARHANI JAN 2 8 2000 32. Registrer's Signature State 2/208 Registrar

DHMH 16 Rev 6/95

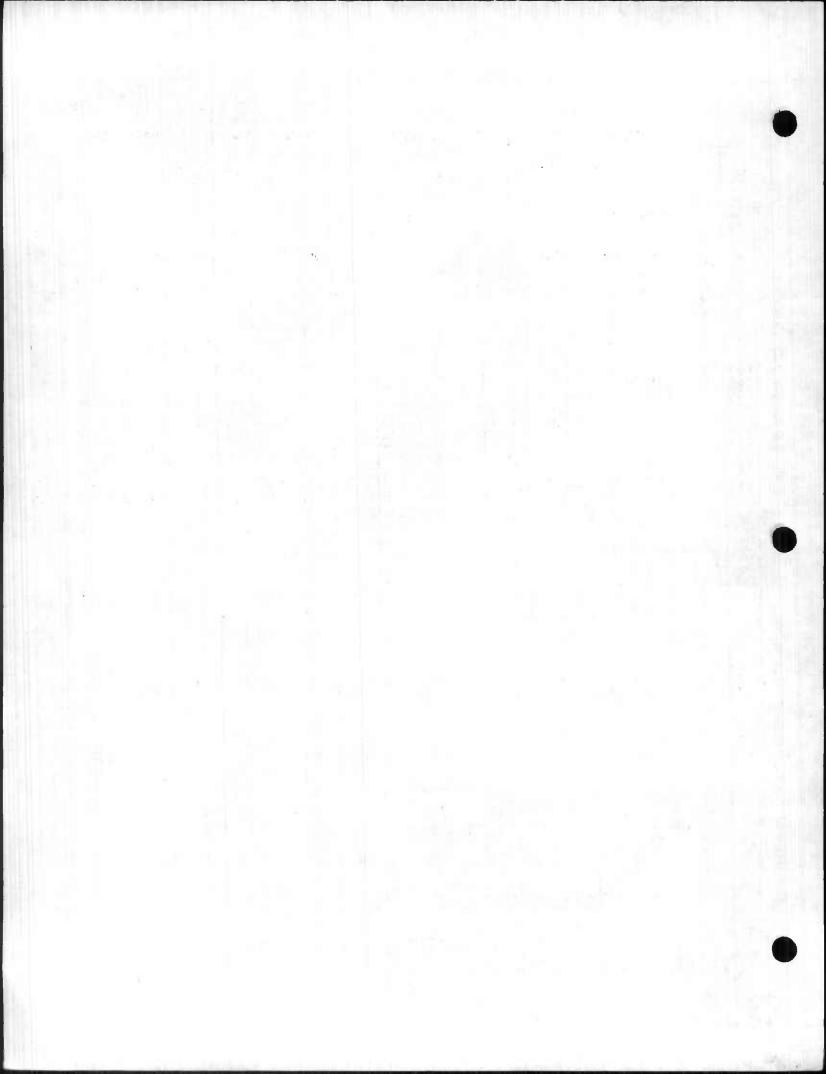
ORIGINAL



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent'a Neme (First, Middle, Last) 2. Date of Death Month **Physician** MILTON STERN **JANUARY** 24, 2000 3:05 PM /Medical 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FUTURECARE CHERRYWOOD NURSING HOME REISTERSTOWN BALTIMORE If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 12 M 2 ☐ F If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 214-14-7005 91 Director DEC. 9,1908 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 25a-f show 1 XYes 2 □ No Director MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? b 2910 TERRY DRIVE #C hems 23a 21209 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, apecify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien. 11. Merital Status Bleck, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Yeer or Detes: 1 Never Merried 2 ☐ Married Baltimore, Maryland 21215-0020 "natural", or 1 ☐ Yes 2 ☑ No Specify: WHITE ģ 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) **OFFICER** BALTIMORE CITY JAIL permit. Pages 1 and 2 should be file. Department of Health and Mental Hy Important: If them 27 is marked other any injury or other treumstic aware 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ISRAEL STERN KATE WEYSMITH 19a. Informant's Neme/Ralationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) GREAT HOWARD S. GOLDSMITH /NEPHEW 121 CAROLSTOWNE ROAD - REISTERSTOWN, MD 21136 20a. Mathod of Disposition 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stata 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from State HEBREW YOUNG MEN CEMETERY 1/27/00 4 ☐ Donetion 5 ☐ Other (Specify) WOODLAWN, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signeture of Funeral Service License 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Pert1. Enter the disease, or *com*plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart feilure. List only one cause on each line. Approximata Intervel Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Congestive ear **Examiner** Examine Cardionyopoth that the death certificate be axecuted physician and is the burial-trans Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequence of): Box 68760, (Oronay Physician/Medical Due to (or as e consequence of) 98 080 P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown Records, þ 24b. Wera autopsy lindings aveilable prior to completion of cause of death? Completed 24a. Wes an autopsy performed? 288 1 ☐ Yes 2 No 1 ☐ Yas 2 ☐ No Division of Vital Be 25. Was case referred to medical axaminer? 26. Place of Deeth (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 415 Nursing Home 5 Rasidence 8 Other (Specify) Certification: To 1 Yes 2 No this 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. tnjury at Work? ne Hospital or Attending Pin 24 hours after death.

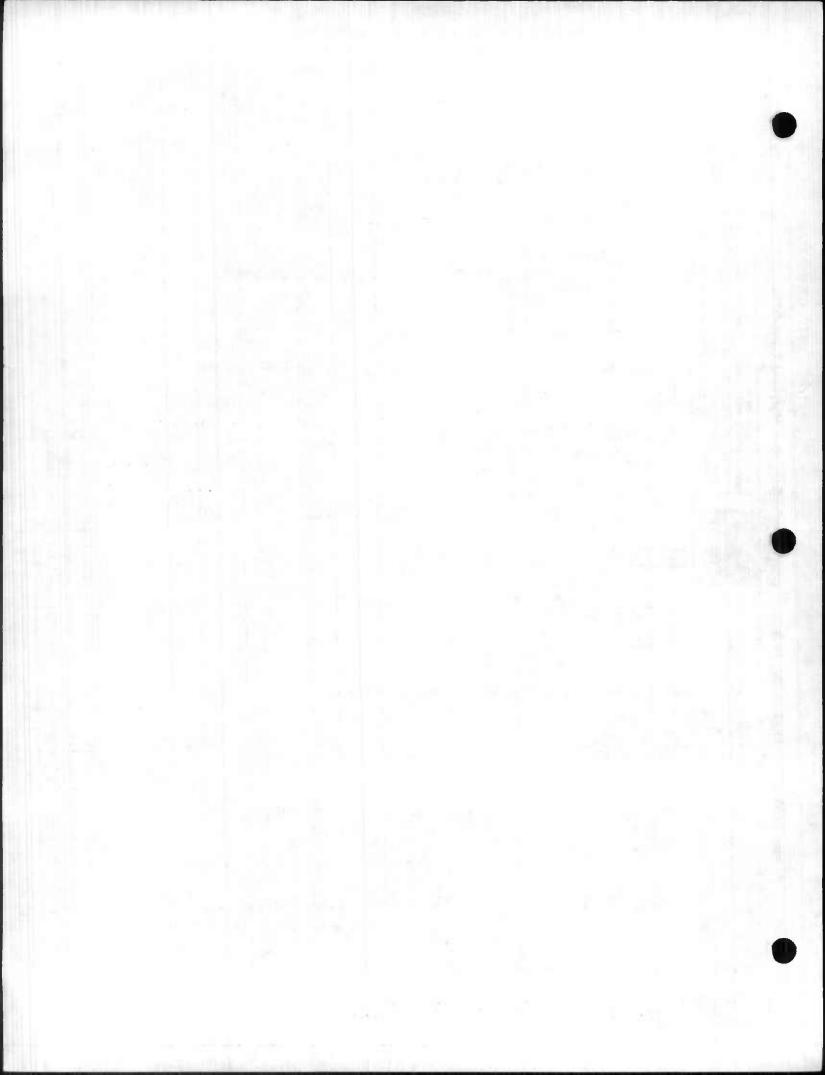
The Funeral Director: After the pietely filled in by the funeral After 1 Aatural 5 Pending 1 □ Yes 2 □ No investigation 2 Accident 6 Could not be detarmined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 - Homicide 29a. Certifier edical 1 To Certifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and due to the cause(s) and menner as stated. To the Hosp within 24 hor To the Fune completely fi 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signeture and little of certifier 29c. License number 29d. Date signed (Month, Day, Year) D37573 Jan 27, 2000 causa of death (Item 23a) (Type, Print) 30. Neme and eddrass of person who comp Heighta Ave Battura MD 71208 7770 AND 7,bel 31. Dete filed (Month, Day, Year) 32. Registrer's Signature State Registrar

8



State of Maryland / Department of Health and Mental Hygien 0 02 1 0 7

| | | | Certificate of | Death | R | eg. No. | 12101 |
|--|--|--|--|--|--|--|---|
| | Decedent's Name (First, Middle, Last) | | | | 2. Data of Dea Month | | 3. Time of Death |
| Physician /Medical• | Ernestine C. Smith | | | | January | | |
| Examiner | 4a Facility Name (If not institution, give street and nur | nber) | | 4b. City, Town, or Lo | cation of Death | 4c. County of De | eath |
| | Genesis Eldercare | | | Severna P | ark | Anne Arı | ındel |
| Funeral Director | 5. Social Security Number 6. Sex 540-14-7479 | 7. Age (In yrs. last birth 80 Y | nday) If Under 1 Year Months Days | Hunder 24 Hrs. Hours Min. | 8. Data of Birth (Month, Day Sept. 7 | Year) 9. B | irthplaca (State or Foreign Country) egon |
| 2 | Usual Residence of Decedent | | | | | | |
| Manylar of ahow | MD Anne Arundel | Severna | | | | | 10d. Inside City Limits 1 ☐ Yas 2 ☒ No |
| or 28=4 a | 10e. Street and Number | | 10f. Zip Code | | 1 | 0g. Citizen of What (| Country? |
| 23a or | 24 Truckhouse Road | | | 144 | | USA | |
| 72 hours after death with the Maryland natural; or Hems 23e or 28=1 show deal Examiner must be notified at sted by Funeral Director | 11. Marital Status 1 Never Married 2 Married 3 Diworced 12. Was Dece Armed Fo | 2 ∑ No | 13. Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2000No | | ecify Yes or No- Rican, atc.) | Black, WI | nerican Indian, nita, etc. White |
| "neturel", deal Fr | 15. Decedent's Education (Specify only highest grade completed) | 16a. I | Decedent's Usual Occup Give kind of work done | pation | ina | 16b. Kind of Busines | s/Industry |
| within the man | Elementary/Secondary (0-12) College (1 | -4or 5+) | Mile. DO NOT use retire | d) | | Advontio | |
| E155 _ | 17. Father's Nama (First, Middle, Last) | Au | ministrato | 18. Mother's Name | /First. Middle. I | Advertis | Ing |
| Mental Hyg Mental Hyg arked other artic avant, To Be C | | | | | | | |
| ahould be and Mental marked o urretic av | | | Madina Address 200 see | | Copeland | | Zin Codel |
| 0 | | (3011) | Mailing Address (Street | | | | |
| emit. Pagas 1 and 3 Separiment of Health important: if Itam 27 iny Injury or other tr anse. | Marcus Edward Copeland S 20m. Method of Disposition | | 1707 Baysic Disposition (Nama of | 1 | - | | |
| 202 | 1 Burial 2XXCremation 3 Removal from 3 | State cemetery | crematory or other pla Crematory | | 1/28/ | 20c.Location-City o | |
| pemit. Pag Department Important: h any injury o | 21. Signature of Funeral Service Licensee 1. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that controls shock, or heart failure. List only one cause on experience of the service of the se | utta | 12 Ridgel | Funeral H y Avenue, | ome, P.A | A. Lis, MD 2 | 21401 |
| death cartificate be synouted a strending physician and of or use as the burial-transit sician/Medical Examiner | disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | Due to (or as a co | onsequence of): Onsequence of): | CARDIO | VAS CU | CAR | 5 YEARS |
| ath cartifulation of the sale | d | ath but not resulting in | the underlying cause di | ven in Part I. | 23b. Did to | bacco use contribu | ta to the cause of deat |
| res that the de- igned by the a be detached i | | | | | 1 🗆 Y | es 2 No 3 | Probably 4 Unkno |
| a been a 2 should pleted | | | | | 24a. Was a perform | | Wara autopsy findings available prior to completion of cause of death? |
| The Land | | | | | 1 □ Y | s 2 No | 1 ☐ Yas 2 ☐ No |
| yatolan: The scartificate director, page Co | 25. Was case referred to medical examiner? | | | 26. Place of Death | n (Check only or | 99) | |
| F | Hospital: | npatient 2 ER/Outp | patient 3 DOA Oth | ner: 4 Mursing Ho | ma 5 Reside | ence 6 Other (S) | oecify) |
| B 5 6 6 | 27. Manner of Death 1 ☑Natural 5 ☐ Pending (Mont) 2 ☐ Accident investigation | | ury Wo | y at rk? Yes 2 □ No | 28d. Describe ho | ow injury occurred | |
| To the Heeplal or Attending P within 24 hours after death. To the Funeral Director: After completely filled in by the funer Medical Certification: | 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place | of Injury - At home, fam ng, etc. (Specify) | n, street, factory, office | | 28f. Location (Si City or Town | | Rural Route Number, |
| ne Hospit n 24 hours ne Funer platsly fill edical | 29a. Certifier (Check only one) 1 Certifying Physician: To the 2 Medical Examiner: On the ba and mann | sis of examination and/ | death occurred at the til or investigation, in my o | me, data and place, ppinion, death occurr | and due to tha co | ause(s) and manner ata and place, and d | as stated. ua to tha cause(s) |
| Me of the or the | 29b. Signature and title of certifier | | 29c. Licens | se number | 2 | 9d. Data signed (Mo | onth, Day, Year) |
| - 5-0 |) AM. 10 | (No | D | 21776 | | | 27 2000 |
| \bigcirc | 30. Name and address of person who completed cause | | vne Print) | | | | |
| 51010 | SUMA P- MENDRA 31. Date filed (Month, Day, Year) 1 32. Ru | My 8 (o | 9 KITU | nie Hu | 27 PCF | AUGNE | + Mp 2112 |
| State Registrar | IAN 28 2000 Series | w 13. | Market | | | | |

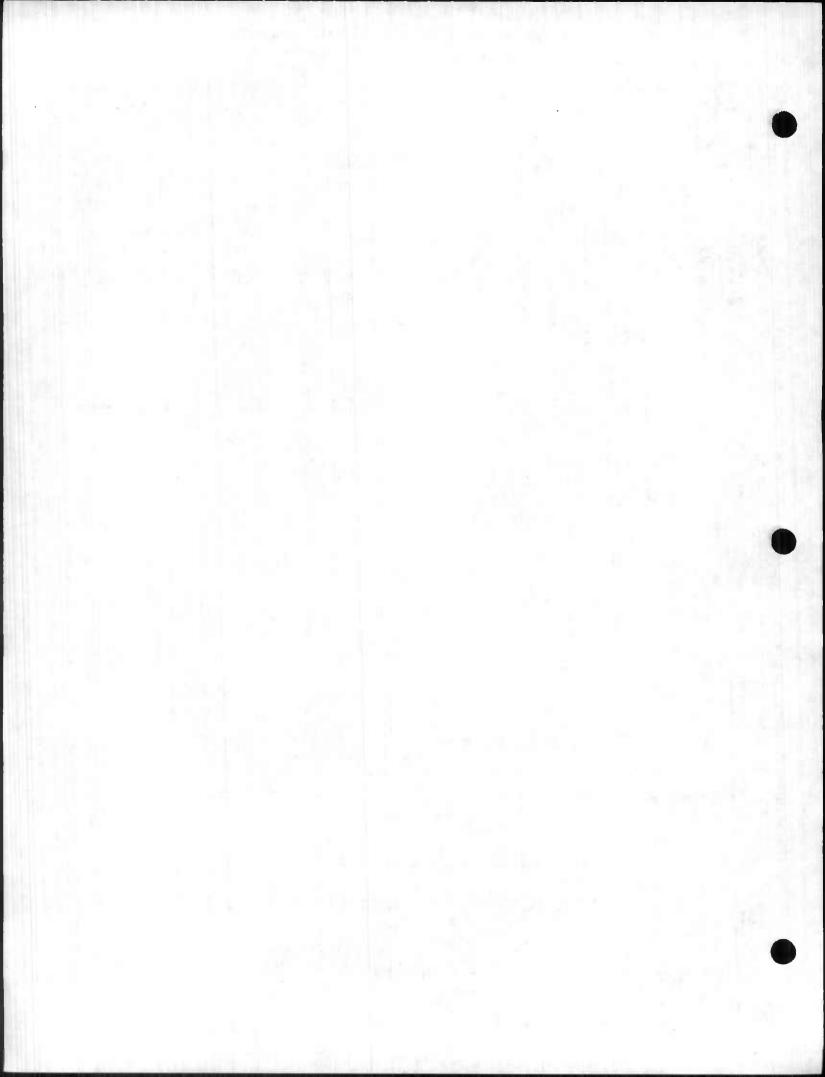


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

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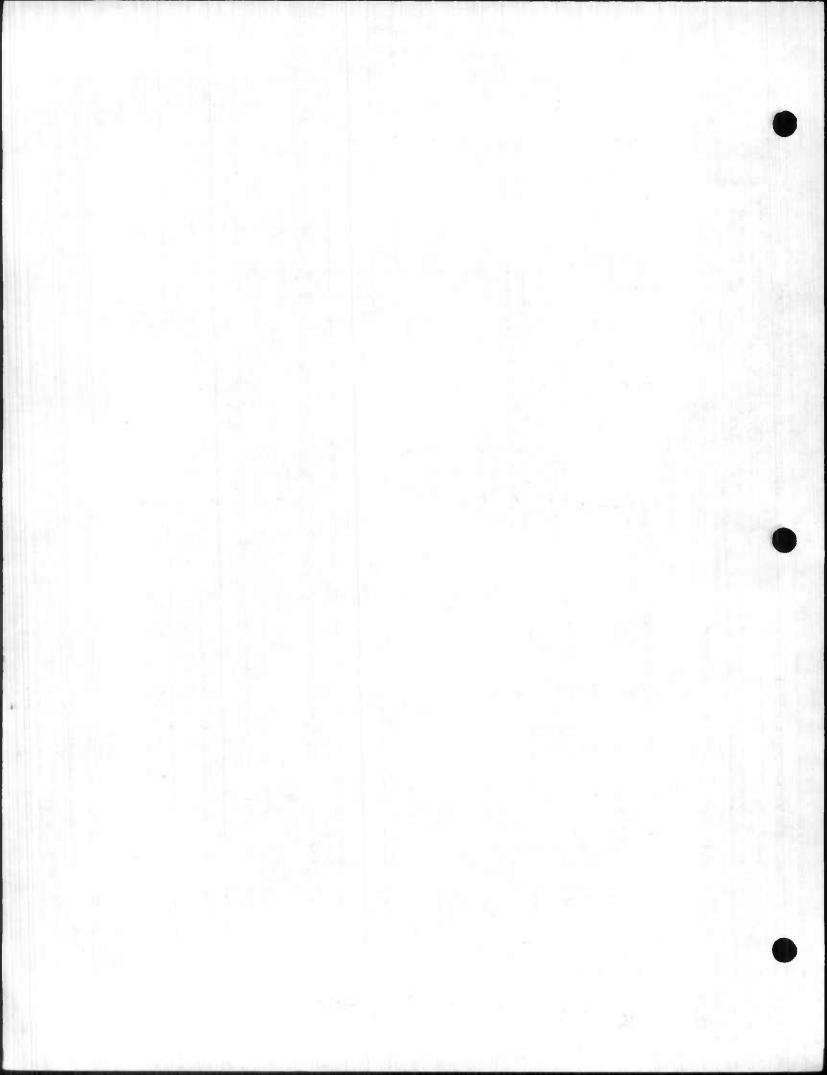
| | | | | Certificate of | Death | F | leg. No. | U | 1100 |
|--|------------------|---|---|--|-------------------------------|---------------------------------|--------------------|-------------|--|
| | | 1. Decedent's Name (First, Middle, La | st) | | | 2. Date of Dee Month | th Day | Year | 3. Time of Death |
| | sician | James J. Sc | chuch | | | January | 22, 2 | | 7:54 a.m. |
| | edical miner | 4a Facility Name (If not institution, giv | e street and number) | | 4b. City, Town, or Lo | | 4c. County | | |
| | | 2802 Glavin Way | Apt. D | | Parkvill | le | Bal | timor | e |
| Fune | ral | Social Security Number 6. 8 | | thday) If Under 1 Year | | 8. Dale of Birth (Month, Day | Vacel | 9. Birthple | ace (State or Foreign |
| Direct | | 212-05-6786 | ØM 2□F 87 | Yrs. Months Days | Hours Min. | August 2 | 7. 1912 | Mar | yland |
| D | | Usual Residence of Decedent | | | | | | | J.= |
| how | | 10a. State 10b. County | 10c. City, Tow | n or Location | | | | 10 | d. tnside City Limits |
| M I | oto | Maryland Balti | more Park | ville | | | | | 1 ☐ Yes 2 🕅 No |
| £ 70 | ire. | 10e. Street and Number | | 10f. Zip Code | | | I0g. Citizen of W | | • |
| 5-0020 72 hours after death with the Manyland netural; or items 23a or 28s-f show | Funeral Director | 2802 Glavin Way | Apt. D | 10 0000 | 21234 | | Unite | d Sta | ites |
| 9 6 | Je J | 11. Marital Slatus | 12. Was Decedent Ever in U,S. Armed Forces? | 13. Was Decedent of I If Yes, specify Cub | Hispanic Origin? (Sp | ecify Yes or No- | 14. Race | - America | |
| Of she was | 3 | 1 ☐ Never Married 2 ☐ Merried | 1 Yes 2 No | 1□ Yes 2X No | | | Specify: | | |
| 21215-0020 d within 72 hours at giene. ir than "natural", or | l by | 3 ☑ Widowed 4 ☐ Divorced | Year or Dates: | 12 103 22110 | арвону. | | Specify. | WN. | ite |
| 15-002 72 hours | Completed | 15. Decedent's Ed (Specify only highest gri | | Decedent's Usual Occup (Give kind of work done life. DO NOT use retire | pation during most of work | ina | 16b. Kind of Bu | siness/Indu | ustry |
| | du | Elementary/Secondary (0-12) | College (1-4or 5+) | | | | M : 11. | Diago | l. ata |
| | Ö | 6 | | Delivery M | | | | Proc | lucts |
| be filed dother | Be | 17. Father's Neme (First, Middle, Last, | | | 18. Mother's Name | | | 9) | |
| | | Peter Schuch | | | Justin | a Blos | 51 | | |
| 2 0 0 2 | | 19a. Informant's Name/Retationship (| | . Meiting Address (Street | | | | | |
| C # N F | | Mrs. Catherine G. | | 2802 Glavi | n Way Apt | | altimore | | 21234 |
| OF G | | 20e. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ | anne ada | Disposition (Name of ry, cremetory or other pla | | Date | 20c. Location - | | |
| altimor nit. Pages artment of ortant: If he | | 4 ☐ Donation 5 ☐ Other (Specif | Garden Garden | ns of Faith | Cem. 1 | /25/2000 |) Balti | more, | Maryland |
| Baltimore, permit. Pages 1 at Important: If Head Important: If Head Important: If Head Into the Intervention of the Interventi | 8 | 21. Signature of Funeral Suprise Licer | Michael E. Canapp | 22. Name and Addre | ess of Fecility | | 5305 Ha | arfor | d Road |
| m 88 E 8 | a | Misse | Cush | Leonard J. | . Ruck. Ir | nc. | Baltimo | re. M | D 21214 |
| | | 23a. Part1. Enter the disease, or com shock, or heart failure. List only | plicetions that caused the death. Do | | | | | | Approximate Interval Batwean |
| Physicia | an | anock, or near rande. Elst only | L / | 4 | | | | | Onset and Death |
| /Medic | | Immediate Cause (Finat disease or condition | 1101192 | DITTONE | Ma | | | / | 1 mon |
| Examin | er | resulting in death) | Due to (or as a | consequence of): | 200 | | | - | 1 |
| | Je L | | U | SERVICE DESCRIPTION | | | | | |
| ox 68760, certificate be executed ading physician and use as the buriet transit | Examiner | Sequentially list conditions. | b. Due to (or es e | consequence of): | | | | | |
| o, o an | Ä | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury | | | | | | i | |
| 68760, flicate be as physician as the buria | edicai | that initiated events resulting in death) Last | Due to (or as a | consequence of): | | | | 1 | |
| 68 milica | Med | Tosoffing in doaling Last | | | | | | 1 | |
| Box 6. | Z-a | _ | d | | | | | | |
| . 0 0 % | Physician/ | Part II. Other eignificant conditions of | onIributing to death but not resulting in | n the underlying cause gi | ven in Part I. | 23b. Did t | obacco use con | tribute to | the cause of death? |
| P.O. that the ded by the detached | Phy | | | | | 120 | /ee 2□ No | 3 Prob | ably 4 Unknown |
| ords, P.O. requires that the een signed by the hould be detached. | by | | | | | | _ | | |
| Records, he law requires to a has been signed 2 should be a | Completed | | | | | 24a. Was | en autopsy med? | eva | re autopsy findings ilable prior to |
| law re | pie | | | | | | | | npletion of cause leath? |
| The lay | E | | | | | 1 D Y | es 200 No | 10 | Yes 2 No |
| Vital Insider: The certificate irector, page | | 25. Wes case referred to medical | | | 26. Place of Deet | h (Check only o | ne) | | |
| of Vita Physicien: this certific | To B | examiner? | Hospitet: 1 Inpatient 2 ER/Ou | stpatient 3 DOA Ot | her: 4 Nursing Ho | -40 | lence 6 Othe | or (Specify |) |
| | | 27. Menner of Death | 28a, Date of Injury 28b. | Time of 28c. Inju | ry at | | ow injury occurr | | |
| DIVISION or Attending I after death. Director: After din by the funei | atio | 1 Selectural 5 Pending 2 Accident investigation | | | Yes 2 No | | | | |
| OlVISIO or Attendi after death. Director: A | <u> </u> | 3 ☐ Sulcide 6 ☐ Could not b | 286. Piece of injury - At nome, re | orm, street, fectory, office | | | Street and Number | er or Rural | Route Number, |
| 그 아이트 | Certification: | 4 Homicide | building, etc. (Specify) | | | City or Tow | m, State) | | |
| ospital hours a uneral ity tilled | | | ysician; To the best of my knowledge | | | | | | |
| 2 2 4 5 | edical | (Check only 2 Medical Exar | niner: On the basis of examinetion en and manner stated. | d/or investigation, in my | opinion, deeth occur | red at the time, o | pate and place, e | and due to | the cause(s) |
| To the To the | × | 29b. Signature and title of certifier, | 20.0 | 29c. Licen | se number | | 29d. Date signed | (Month, E | Day, Year) |
| N | 13 | - Charles VI | reststau) | DI | 5546 | | Jan 2 | 5,2 | 000 |
| (IV | W | 30.(Name and address of peraper who | completed cause of death (Item 23s) | (Type Prim) | 0 0 | 000 | | 110 | 3.200 |
| | 1770 | Charlestantion | HUD 5601 | od Kreeg | H WUX | Dett | More | M. | 122 |
| ø. | State | 31. Date filed (Month, Day, Year) | 32. Registrar's Signature | 1 | 1 | | | | |
| | istrar | JAN 2 8 2000 | Beneve B | Sparks | | | | | 8 |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

| | Decedent's Name (First, Mi | | ate of fee | ai yiai id | • | icate of | Death | 2. Date of De | Reg. No. | 02109 3. Tima of Death | | |
|------------------------------|--|-------------------|---|----------------------|-----------------------------------|------------------------------------|---|---|---|--|--|--|
| sician | | Louis | • | Cah | | | | Month | Day | Year | | |
| edical | Bernadine | | | SCI | umacher | : | th City Town or | Janua: | 4 | 00 8:30 am | | |
| iner | 4a Facility Name (If not institu | | | | | | 4b. City, Town, or | | | | | |
| | Annapolis Nu | | | | | | Annapoli | | Anne A | | | |
| | 5. Social Security Number 312–16–7600 | 6. Sex 1 ☐ M 2 | | e (In yrs. las 77 | | Under 1 Year onths Daya | | | | 9. Birthplace (State or Foreig Country) Indiana | | |
| | Usual Residence of Decedent 10a. State 10b. Cou | nty | | 10c. City, 1 | Town or Location | on . | | | | 10d. Inside City Limits | | |
| ဗ္ဗ | MD Ann | e Arund | el | Annar | olis | | | | | N☐ Yes 2☐ No | | |
| Director | 10e. Street and Number | | | | 1 | Of. Zip Code | | | 10g. Citizen of Wh | on of What Country? | | |
| 5 | 1749 Drevar T | rail | | | | 2140 | 1 | | USA | | | |
| by runeral | 11. Marital Status 1 Never Married 2 N 3 Widowed 4 Divor | arried 1 [| as Decedent E med Forces? □Yea 2√□N Yes, Give ear or Dates: | | | Decedent of Is, specify Cub | Hispanic Origin? (S van, Mexican, Puer Specify: | Specify Yes or No to Rican, etc.) | | American Indian, White, etc. White | | |
| | 15. Dece (Specify only hig Elementary/Secondary (0-1: 1.2 | | | | life. DO N | of work done IOT use retire | during most of wo | orking | 16b. Kind of Busi | | | |
| ŀ | 17. Father's Name (First, Midd | (a ast) | | | Homema | aker | 18 Mother's Na | me /First Middle | , Maiden Sumame | | | |
| | Herbert H. Mau | | | | | | | I. Merke | | | | |
| 2 | | | | 1 | 401 14 15 | | | | 1 per, City or Town, State, Zip Code) | | | |
| | 19e. Informent'a Name/Relation | | | | | | | | | | | |
| - | Sherrilyn A. T | urner - | Daught | | . /49 Dre | | rail, Ann | | | | | |
| | 20a. Method of Disposition 1 Burial 2 Crematic 4 Donation 5 Other | | al from State | cem | etery, cremator | ry or other pla | ice) | Jan. 22, 2000 | Baltimor | e, MD | | |
| | 21. Signature of Funeral Servi | ce Licensee | Kutt | a. | Ha | ardesty | ess of Facility Y Funeral Ely Avenu | | P.A. polis, MD | 21401 | | |
| Je. | 23a. Part1. Enter the disease shock, or heart failure. I Immediate Cause (Final disease or condition resulting in death) | ist only one cau | Al | che | s a consequence | -3 | | | | Approximate Interval Between Conset and Death | | |
| riiysiciaiymedicai Examinisi | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): Due to (or as a consequence of): | | | | | | | | | | | |
| | Part II. Other algnificant cond | tions contributir | ng to death bu | t not resultir | ng in the under | ying cause gi | ven in Part I. | 23b. Did | tobacco use cont | ributa to the cause of death | | |
| | | | | | | | | 10 | Yes 213 No 3 | B Probably 4 Unknow | | |
| | | | | | | | - | | s an eutopsy ormed? | 24b. Were autopsy findings available prior to completion of cause of death? | | |
| | | | | | | | | 10 | Yea 2 No | 1 ☐ Yes 2 ☐ No | | |
| | 25. Was case referred to med | cal | | | | | 26. Place of De | eth (Check only | one) | | | |
| | examiner? | Hospita | il: 1 🗆 Inpatier | nt 2□ER | VOutpatient 3 | DOA O | her: 4 DiNorsing I | Homa 5 ☐ Res | idence 6 Other | (Specify) | | |
| Cermication: 1 | 27. Manner of Death 1 Natural 5 Pen 2 Accident inve | | . Dete of Injun (Month, Day | Year) 28 | Bb. Time of Injury | 28c. Inju Wo | ry at vrk?] Yes 2 □ No | 28d. Describe how injury occurred | | | | |
| | 3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | | | 281. Location (Street and Number or Rural Route Num City or Town, State) | | | |
| Calical | 29a. Certifier (Check only one) 1 Certification 2 Medication 1 Medication 1 Certification 1 Medication 1 Certification 1 Certi | al Examiner: Or | To the best of n the basis of nd manner atal | examination | dge, death occ and/or investig | urred at the ti pation, in my o | me, date end place opinion, death occu | e, and due to the urred at the time, | cause(s) and man date and place, an | ner as stated. id dua to the cause(s) | | |
| ¥ | 29b. Signature and title of self- | fier | / | | | 29c. Licen | se number | | 29d. Date signed | (Month, Day, Year) | | |
| | 1 | 15 | | - | | U. | 3803 | | 1-10 | 7000 | | |
| - | 30. Name and address of place | Nation and the | ad course of de- | with the - co | On) (Trans Sales | | | | | 2000 | | |
| 1 | Brian S. Ka | han, D | 0 16 | 10 W | est Sto | get s | Suitell | o Ann | apolis, | Md. 21401 | | |
| ate rar | 31. Date filed (Month, Day), Ye. | 2000 | Seper | i s Signeture | D. A | porks | | | | | | |

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Dete of Death 3. Time of Deeth Month David A. Shrewsbury, Sr. January 21 2000 10:44 am 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death North Arundel Hospital Glen Burnie Anne Arundel If Under 24 Hrs. Hours Min. If Under 1 Year 5. Social Security Number 7. Age (In vrs. last birthday) 8. Deta of Birth (Month, Day, Year) Birthplaca (Stata or Foraign Country) Months Deys 234-60-1347 1 M 2 □ F 60 12,1939 Sept. West Virginia Usuel Rasidance of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits Anne Arundel Odenton 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1200 Baliol Lane 21113 USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian. 11. Maritel Status Bleck, White, etc. 1 ⊠ Yes 2 □ No If Yes, Give Year or Detes: 1957-61 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Installer/Distributor 12 Carpet 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Claude Shrewsbury Sylvia L. Braggs 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Steta, Zip Code) 19e. Informent's Name/Ralationship (Type, Print) David A. Shrewsbury, Jr. (Son) 498 Bruce Avenue, Odenton, MD 21113 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, State 01/28/ 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from Steta Metro Crematory 2000 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Addrass of Facility 21. Signature of Funerel Service Licenses Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401 LA 23a. Pert1. Enfar the disease, or complications that caused the deeth. Do not entar the mode of dying, such as cardiac or respiratory errest, shock, or heart tellura. List only one cause on each line. Approximate Intarvai Batwaan Onset and Death Immediate Cause (Finel diseasa or condition resulting in death)

Physician /Medical Examiner

Physician

/Medical

Examiner

10a, State

MD

Director

Funeral

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Completed

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Funeral

Director

288-4

8 finer mant be

'natural', or than dical Examiner

Hygiene.

Pages 1 and 2 should be fit ment of Health and Mental H tant: If hem 27 is marked off jury or other traumatic even

the Maryland

death

filed within 72 hours after

Baltimore, Maryland 21215-0020

the bunal-transit

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signed by the attending be detached for use

certificate

this

After 1

within 24 hours after death. To the Funeral Director: A

Hospital

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funeral

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Medical Certification: To

The law requires that the death certificate be executed

Box 68760,

P.O.

Records,

Division of Vital or Attending Physician:

Examiner Sequentially list conditions, if any, laading to immediata causa. Entar Underlying Cause (Disease or Injury thef initieted events rasulting in death) Last Physician/Medical Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. by Completed

25. Wes case ratarred to medical axaminer?

29b. Signature and title discertifier

1 Yes 2 No

27. Manger of Death

1 Natural

2 Accident

3 Suicide

29a. Cartifier

4 ☐ Homicide

(Check only one)

1001 Dua to (or as a consequence of) Due to (or es a consequence of):

24a. Was an autopsy performed? 1 Yes

23b. Did tobacco use contribute to the cause of death2 1 Yee 2 No 3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of daath?

1 Yes 2 No

26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Rasidence 6 Other (Specify)

2 PM

28d. Describe how injury occurred 1 Yas 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

16 Certifying Physician: To the best of my knowledge, daath occurred at the time, date end place, end due to the cause(s) end menner as stated. 2 Medical Examiner: On the basis of examination end/or invastigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) end manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

111954

28c. Injury at Work?

1-21-00

30. Nome and address of person who completed cause of death (Item 23a) (Type, Print) Defense Hwy Gambulls, MD 21054
Robert L. Batsleer M.D. 1438 Defense Hwy Gambulls, MD 21054 Robert 31. Date filed (Month, Day, Year)

Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA

28b. Tima of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

26a. Data of Injury (Month, Day Year)

State Registrar

JAN 28 2000

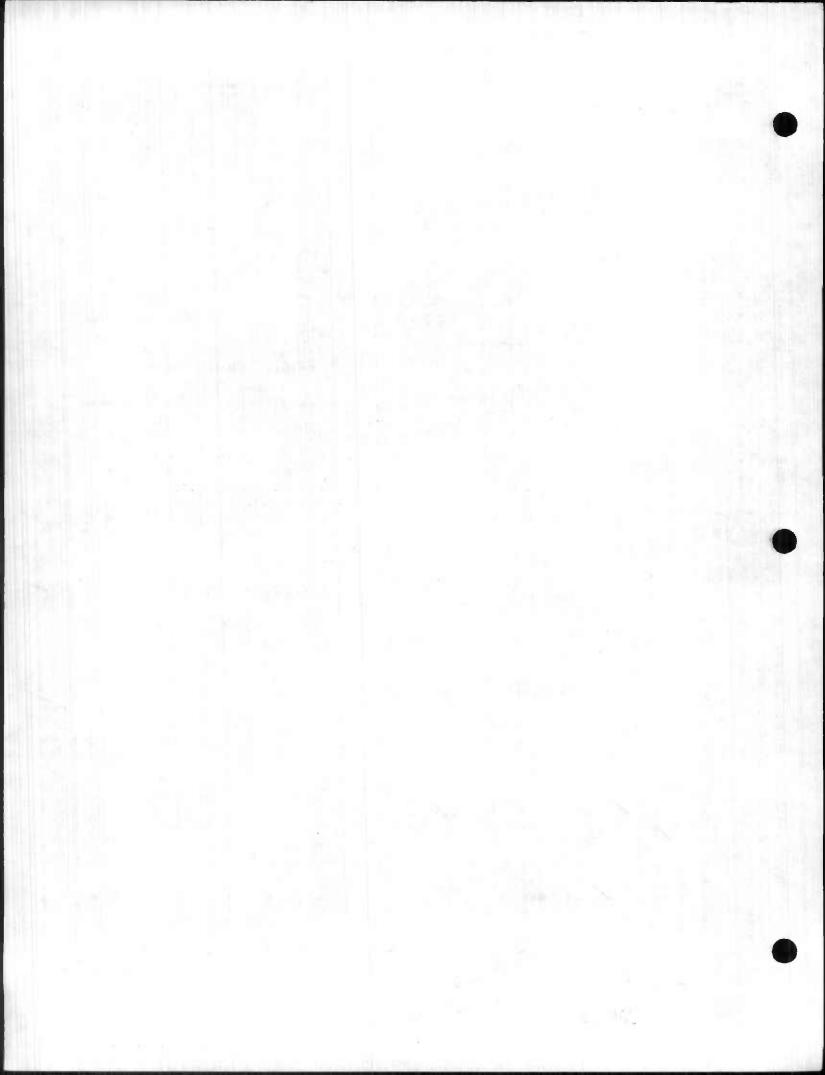
5 Pending invastigation

6 Could not be detarmined

32. Registrer's Signeture

BHMH 16 Rev 6/95

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 4:55 **Physician** 21 /Medical 4a Facility Name (finot institution, give stre 4b. City. Town, or Location of Death 4c. County of Deeth Examiner If Under 1 Yea If Under 24 Hrs. Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Year) 1 M 2 F 78 166-18-7047 **Birector** 11,1921 April Pennsylvania Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No Director MD Anne Arundel Edgewater Name 23s or 25s-1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 915 Fairview Road 21037 USA Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 11 Marital Status filed within 72 hours after 1 Yes 2XNo
If Yes, Give
Yeer or Detes: 1 Never Merried 2 Merried 8 Baltimore, Maryland 21215-0020 1□ Yes XXNo Specify: ğ White 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ARINC Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) Be Pages 1 and 2 should be nent of Health and Mental Stotts Singer Marguerite Shanno 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Neme/Relationship (Type, Print) . 4 Smithfield Village, East Stroudsburg, PA 18301 William K. Young (Son) or other tr 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 01/24/2000 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Metro Crematory 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 21. Signature of Funeral Service Licens 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be axecu physician the buria Box 68760. Physician/Medical Due to (or es a consequence of): 88 980 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. been signed by the should be detached 1 Yes 2 No 3 Probably 4 ☐ Unknown Records, py 24b. Wera autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? page 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital 25. Wes case referred to medical examiper? or Attending Physician: Be 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Nes/ 2 No 3D DOA 1 Inpatient 2 ER/Outpatient this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After 5 Pending investigation 1 Natural 1 TYes 2 No 24 hours after death. 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 6 Could not be determined 3 Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital 1 Fertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29a. Certifier Medical pletely (Check only one) Within 2 To the COT 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature end title of certifie cause of death (Item 23a) (Type, Print)

DHMH 16 Ray 6/95

State

Registrar

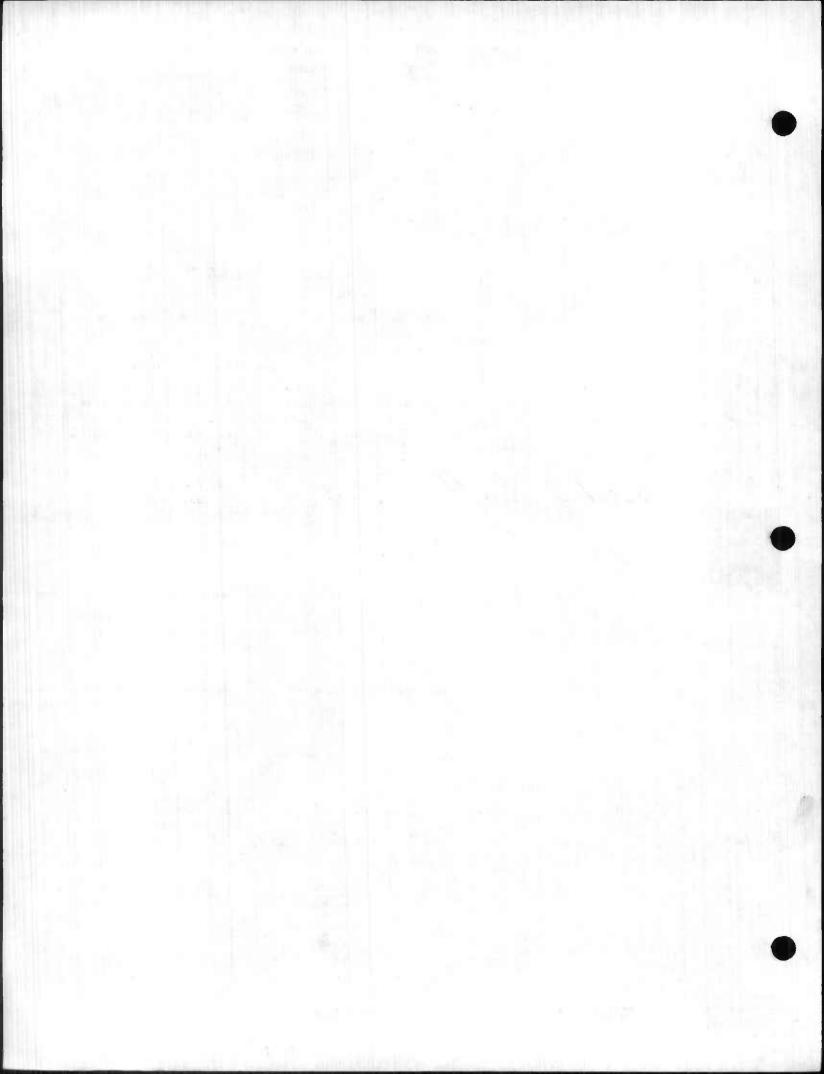
31. Dete filed (Month, Day,

JAN

2 8 2000

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Registrar's Signature



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|------------|---|--|---|-----------------------|---|------------|----------------|----------------|----------------------------|--|--------------------------|-----------------|--|---------------------|--|---|--|
| 3 | Physiciar /Medica | 1 | Decedent's Name (First, Middle VERDELL BERT | | MIT | H-PA | RKER | | | | | | 2. Date of Dec Month JANUA | Dav | Yaar ' | Time of Death 2124 PM | |
| | Examine | | a Facility Name (If not institution BON SECOURS He | | | mber) | | | | | b. City, To BALTI | | ocation of Death | 4c. County | | | |
| | Funeral Director | 1 | Social Security Number | 6. Sex 1□ M | 2∏ F | 7. Age (II | yrs. last birt | | If Undar 1 Yo Months De | | If Under Hours | 24 Hrs. Min. | 8. Date of Birt (Month, De) Mar. 1 | Year) 1952 | 9. Birthplaca Country) MD | (Steta or Foraign | |
| | the Maryland 28a-f show notified at | 1 | Jsuat Residence of Decedent Oa. State 10b. County MD NA | | | | c. City, Town | | | | | | | | | nside City Limits | |
| | 6 9 5 | 2010 | 0e. Street and Number 2405 ST. STE | EPHEN | IS C' | г. | #3B | | 101. Zip Cod 212 | | 7 | T. | | 10g. Citizen of USA | g. Citizen of What Country? | | |
| 020 | urs after des aft, or items Examiner in | 2 | Marital Status Never Married 2 Man Widowed 4 Divorced | ried | Was Deci Armed Fo 1 Yas If Yes, Gi Year or D | 2X No | r in U,S. | | | Decedent of Hispanic Origin? (Specify Yes or No- t, specify Cuban, Mexican, Puerto Rican, atc.) (as \times No | | | | | No- 14. Raca - American India Black, White, etc. Specify: BLACK | | |
| 21215-0020 | ad within 72 ho ygienti. wer than "natura 4, the Medical a | The state of the s | 15. Deceden (Specify only highe Elementary/Secondary (0-12) | st grade co | de completed) (Give kind of work d life. DO NOT use n | | | | | | | | ing | | usiness/Induatr | | |
| Maryland 2 | Mental Hygier thanks other thanks other thanks other thanks other thanks of the file avent, the | 3 | 11th 7. Father's Nama (First, Middla, GORDON SMITH | | NA | | WA | REH | OUSE | USE WORKER CANDY FACTORY 18. Mother's Name (First, Middle, Meiden Sumeme) SARAH LLOYD | | | | | RY | | |
| | 1 and 2 short fealth and 3, im 27 is me ther traums | 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Str. CHERYL TUCKER - SISTER 1127 N. MONROE ST. BALTIMORE, MI 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City | | | | | | | | | | MD 21 | 217 | | | | |
| Baltimore | it. Pages inment of I reant: if lie njury or of | | PAI Bunal 2 Litermation 3 Linemoval from State | | | | | | | | | | | | | | |
| | Physician /Medical | | 23a Portt. Enter the disease, or shock, or hear tailure. List | complicationly one co | | | | 43 ot enter | OO WA the mode of | B / dying | IERA] SH , such as | L HC | ME WES | ST, IN | D 212 | 15 proximate pro | |
| E | Examiner | Immediate Cause (Final disease or condition resulting in deeth) NARCOTIC INTOXICATION Due to (or as a consequence ot): | | | | | | | | | | | | | | | |
| ,092 | be executed cian and burial-transit | | Sequentiatly list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events Due to (or as a consequence of): | | | | | | | | | | | | | | |
| x 687 | 0 % 0 | | Ceuse Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): d | | | | | | | | | | | | | | |
| P.O. | y the day the sched | | | | | | | | | e give | n in Part I | l. | | | | cause of death? | |
| ec | aw requires to be significated by | | | | | -4- | | | | | | | | an autopsy rmed? | availab | sutopsy findings te prior to tion of cause h? | |
| | certificate ha | - | | | | | | | | | | | 10(1 | | 1 🗷 (Ye | s 2 No | |
| of Vital | |) | 25. Was case reterred to medica examiner? XXX Yes 2 No | Hosp | oitat: | Inpatient | anen/ou | nationt | 2 DOA | Othe | hr" | | th <i>(Check only</i> o | | os (Cassibi) | | |
| | E E M | - | 7. Manner of Death 1 Natural 5 Pendir 2 Accident investi | gation f | 8a. Date | ot Injury | | ime ot jury | 28c. l | Injury Work | | | 28d. Describe I | | | own | |
| = | a Hospital or Attends 24 hours after death. 5 Funeral Director: A selely filled in by the it | 27. Manner of Death Natural 2 Accident 3 Suicide 4 Homicide 4 Homicide 4 Homicide 29a. Certifier (Check only one) 29a. Certifier (Check only one) 27. Medicat Examiner: On the bast of examination and/or investigation of things 28b. Time of things 28b | | | | | | | | | | | _ | | | | |

State Registrar

DHMH 16 Rev 6/95

Stephen 5.
31. Date tited (Month, Dey, Year) JAN 2 8 2000

30. Name and address of person who completed cause of death (Repr23a) (Type, Print)

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In padents

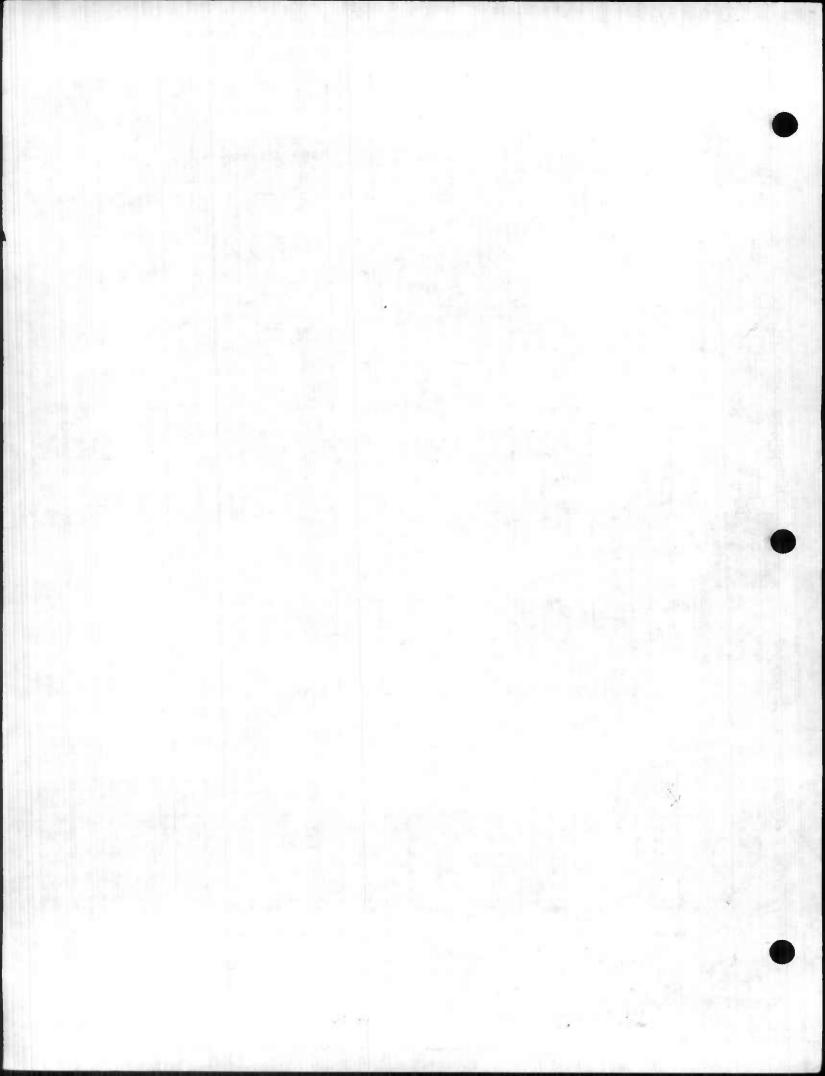
In penn Street, Baltimore, Maryland 21201 Radentz 111 Pe

29c, License number

O.C.M.E.

29d. Data signed (Month, Day, Year)

JANUARY 21, 2000



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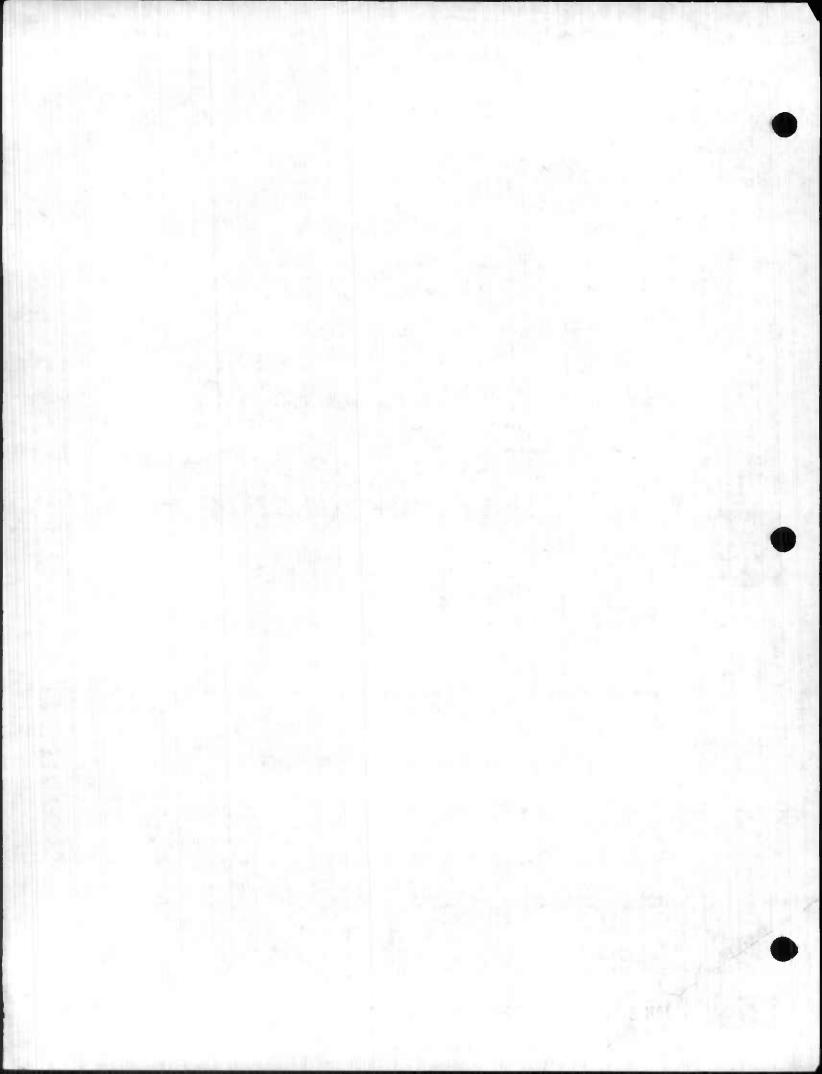
| Robert | C. | Shenk | |
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death

| | | Oertincate t | JI Deall I | R | leg. No. | | |
|--|---|--|--|-------------------------------------|-------------------|------------------------------------|--|
| 1. Decedent's Name (First, Middle, La | C. SHel | OK J.R. | | 2. Date of Dea Month Januar | Day | Yaar | Time of Death 1:20 PM |
| 4a Facility Nama (If not institution, give | | | 4b. City, Town, or L | ocation of Death | 4c. County | of Death | |
| | del General Hos | pital | Annapoli | S | Anne | Arunde] | |
| | Sex 7. Age (In yrs. las | st birthday) If Under 1 Ye | aar If Under 24 Hrs. | | | 9. Birthplace | Stete or Foreign |
| 110010799 | 12M 2DF 54 | Yrs. Months De | eys Hours Min. | Dec. 62 | 1945 | Country) | |
| sual Rasidence of Decedent | 0,7 | | | TUCE LIDA | | | / |
| 10a. State 10b. County | 10c. City, | Town or Location | | | | 10d. ir | side City Limits |
| pn Cul | 25/2410/ | Cama | 11'11 | 00 | | 1 | Yes 2 No |
| 10e. Street and Number | erland | Camp 1 101. Zip Coo | 40 | P , P | IOg. Citizen of V | What Country? | |
| | 11 01 | 101. 2ip 000 | 4.4 | | og. Chaen or e | - Country | |
| 369 NOTH 2 | 7m Street | + 17 | 011 | | U. | SA | |
| , Marifal Status | 12. Was Decedent Ever in U,S. Armed Forces? | . 13. Was Decedenf If Yas, specify (| of Hispanic Origin? (Sp Cuban, Mexicen, Puert | pecify Yes or No- o Rican, etc.) | 14. Hac | e - American In ck, White, etc. | dian, |
| 1 ☐ Never Married 2 ☑ Married | 1 Yes 2 No | 1 ☐ Yes 2 Ø | No Specify: | | Specify | , | , |
| 3 ☐ Widowed 4 ☐ Divorced | Year or Dates: | | | | Speciny | Whi | te |
| 15. Decedent'a E | | 16a. Decedent's Usual Oc | ccupation | kina | 16b. Kind of Bu | usiness/Industry | |
| (Specify only highast grant (0-12) | Collega (1-4or 5+) | | one during most of worthired) | A III | 0+61 | etic | . (0). |
| 12 | 4 | PRES | ident | | MIN! | 0,,0 | |
| 17. Father's Name (First, Middle, Last |) | | | ne (First, Middle, | Maiden Suman | na) | |
| Robert C Sh | enk SR. | | Dorot | by C- | 0000 | walt | 4 |
| 19a. Informant'a Name/Retationship | | 19b. Mailing Address (St. | | | | | |
| | | | 1.1 01 | | . 1 | 1:11 01 | 17011 |
| Judith Diane S | | 369 North | | | amph | City or Town, S | 1 10 11 |
| 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ | DRemoval from State | ce of Disposition (Neme on entery, cremetory or other type) 1 than 15 than 22. Name and A | placa) | 0/3/636 | 20C. LOCATION - | City or Town, a | nate |
| 4 Donation 5 Other (Speci | ty) Fas | + Harris Buc | a Cemetery | 211100 | HARRISI | berg 1 | P. A, |
| 21. Signature of Funeral Service Lice | nsee / | 22. Name and A | dress of Facility | - Enn | OFAL | Homo | 2 |
| 1 1 1 9 | 1 11/1 | HOFTIC | 11/2001 6 | 20-1 001 | 0 11 | 1 00 / | 110011 |
| Phys Enter the disease or con | (II - Line will y | 1001 | (())) | mer me | 1 1 2 14 1 11 | O TINC | roximete |
| Shock, or heart failura. List only | ona cause on each line. | DO HOLDHOL HIGHWOOD OF | dynig, buoir ou burance | or respiratory and | | Inte | vai Between et and Daath |
| Immediate Course (Final | 7 | | | | | | |
| Immediate Cause (Final disease or condition resulting in death) | . Drowning | and Hupothi | ermia | | | | |
| | | as a consequente of): | | | | | |
| _ | h | | | | | | |
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| that initiated events | C. Due to (or a | is a consequence of): | | | | | |
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| | d | | | | | | |
| Part II Other significant conditions | contribution to death but and arrive | ing in the unitarities are: | o chien in Don't | 22h DI-44 | obacco use so | ntribute to the | cause of death |
| Part il. Other significant conditions | Junioring to death but not result | ang in the underlying ceuse | e given in ran 1. | | | | cause of death |
| | | | | 101 | res 2 No | 3 Probably | 4 Unknow |
| | | | | | | 04h 141 | dones feeting |
| Part II. Other significant conditions of | | | | 24a. Was a | med? | availabl | utopsy findings e prior to fion of causa |
| | | | | | | of death | 17 |
| | | | | 1 5 LY | es 2 No | 1 PYe | 2 □ No |
| 25. Was case referred to medical | | | 26 Dines of Day | | | | |
| axaminer? | Hospital: | | Other: | ath (Check only or | | | |
| 27 Manner of Death | 1 L Inpatient XXXX | | 4 Li Nurskig n | lome 5 Resid | | | |
| 27. Manner of Death 1 □ Naturat 5 □ Pending | (Month, Day Year) | 28b. Time of 28c. | Injury at Work? | 28d. Dascribe h | | near boat | /deck |
| 2 Accident investigation | 1-25-00 | 10.55 A | 1 ☐ Yes 2 MNo | Jan College | 10001146~ / | 1000 - 000 | 701000 |
| 3 Suicide 6 Could not be determined | 28e. Plece of Injury - At hom building, etc. (Specify) | ne, farm, atreet, factory, of | fice | 281. Location (S City or Tow | | ber or Rurel Roo | ite Number, |
| | 1 | y dock | | Annam | 10 /4/1 | y Deck | |
| | hysician: To the best of my knowl | edge, deeth occurred at th | | | | | |
| | miner: On the basis of examination and manner stated. | | | | | | |
| 29b. Signatura and the of certifiar | | 29c. Lic | cense number | | 29d. Data signe | ed (Month, Dey, | Year) |
| 11 | 1001 | 0.0 | C.M.E. | | | 7 27, 20 | |
| Henry | - Chuton | | | | January | 2 7 7 20 | |
| 30. Nama and addrass of person who | pempleted ceuse of death (Item 2 | 23a) (Type, Print) | mot Balt | imom A | (arrel arre | 1 21201 | |
| lennie J. | Chute no | 111 Penn St | Teer, Ball | THOTE, N | латАтатк | 1 21201 | |
| 31 Data filed (Month Day Year) | 32 Begistrer's Signatur | 10 | | | | | |

JAN 2 8 2000 Registrar

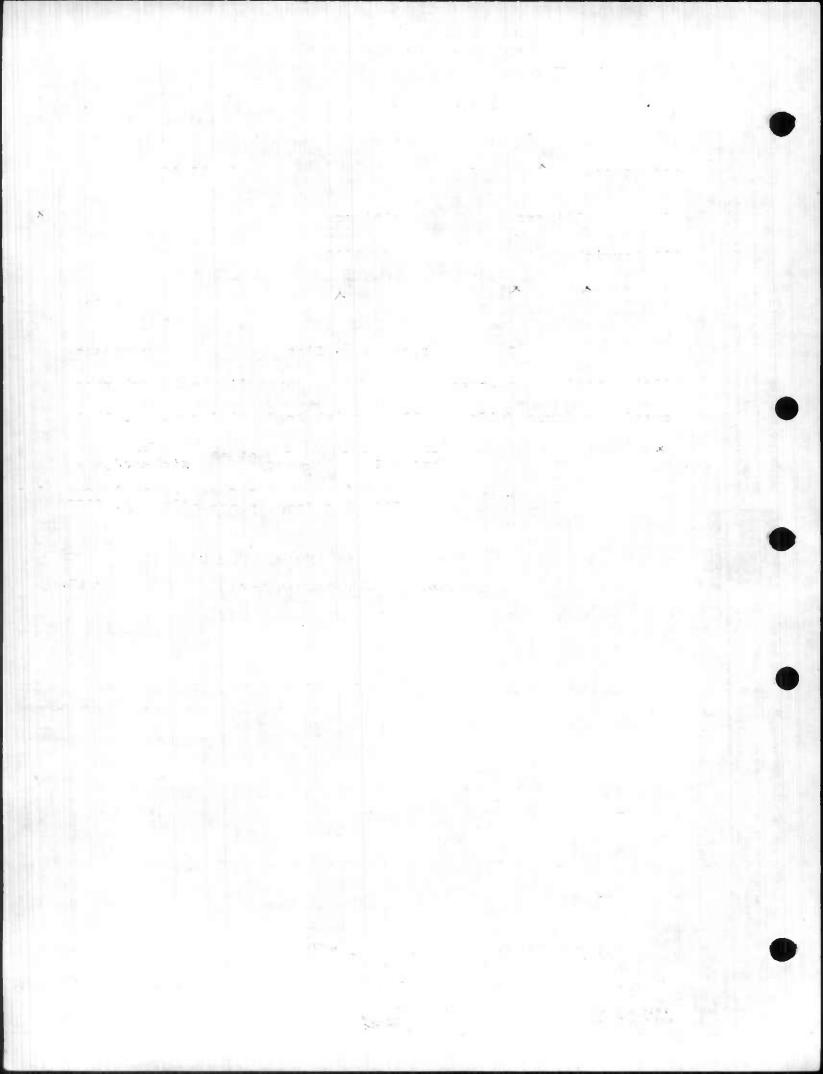
DHMH 16 Rev 6/95



Please Type or Print in Black Indelible ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 2 |

| n | 1. Decedent's Nama (First, Middle, Last) ROBERT SANDERSON 2. Data of Death Month Day Ye TAWAN 21 200 | | | | | | | | | | | , | Year | 3. Time of De | |
|---|--|--|---|--|--|--|---|--|--------------------------------|---|---|------------------------------------|--|--|-----|
| l | KOE | BENT | 51 | ANDE | RSON | | | | | JANUA | m 21 | . 20 | | 3:29 | |
| | | (If not Institution, given | | | all . | | | 4b. City, Tov | vn, or Loc | cation of Deat | | ounty of | | | |
| | HONT | HWEST | HOSPIN | 14 | CENTI | | | / | | istown | | 3/12 | TIM | one | |
| | 5. Social Security 225-60 Usual Rasidance | -0084 | Sex 12X M 2□ F | Age (In yrs. | last birthday) Yrs. | If Under Months | 1 Year Days | If Under 2 Hours | Min. | | | | 9. Birthpla Country | ce (State or F V) VA | |
| 1 | 10a. State | 10b. County | | 10c. Ci | ty, Town or Lo | cation | | | | | | | 100 | d. Inside City I | |
| | Md | Baltin | nore | | Ba | ltime | ore | | | | | | | 1 Yes 2 | |
| The section | 10e. Street and No | | | | | 10f. Zip | | | | | 10g. Citizen of What C | | | v? | |
| | 732 Wa | rwick Ro | na d | | | | 122 | q | | | USA | | | | |
| 1 | 11. Marital Status | | 12. Was Decede | nt Ever in U | J.S. 13. V | | | | in? (Spe | cify Yes or No | | | - American | n Indian, | |
| | | rried 22 Married | Armed Force 1 XYas 2 If Yas, Giva Yaar or Date | □No | | | | ent of Hispanic Origin? (Specify Yes or No- fy Cuban, Mexican, Puerto Rican, etc.) No Specify: | | | | Black, Whita, etc. Specify: White | | | |
| ľ | | 15. Decedent's E | ducation | | 16a. Deced | dent's Usua | I Occup | ation | | | 16b. Kind | of Busi | iness/Indu | | |
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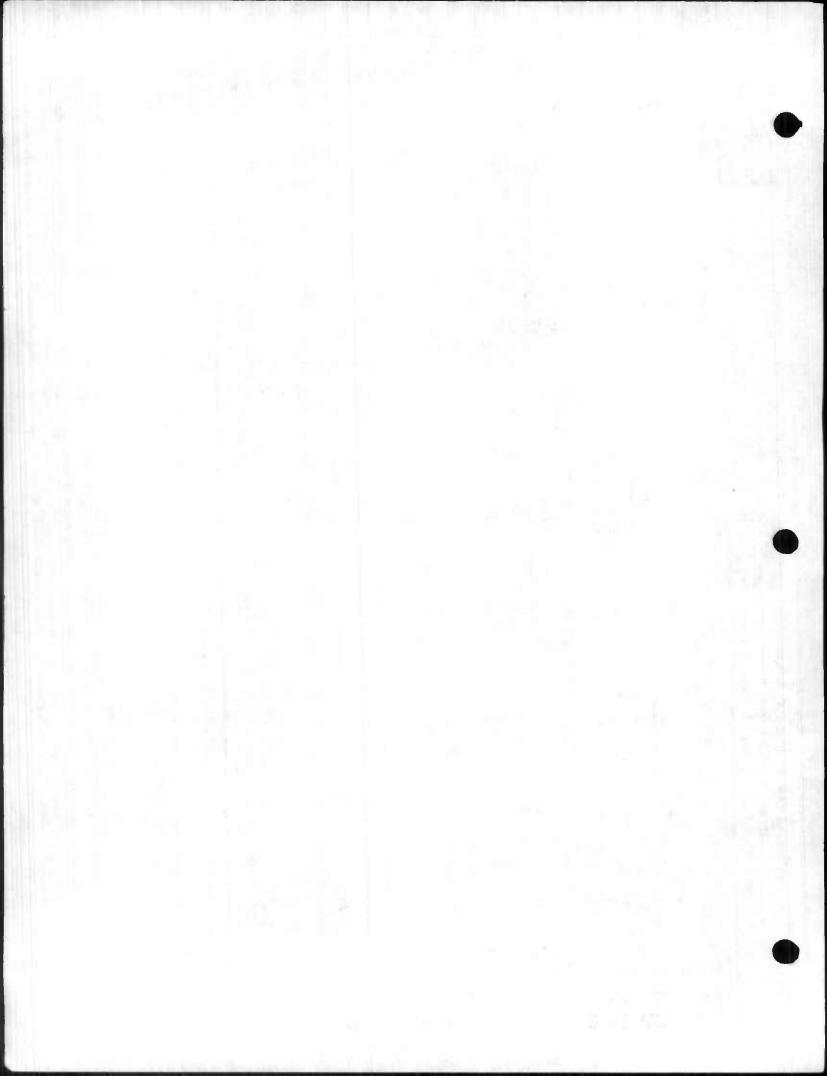


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

| Molly E. Samuelson Molly E. Samuelson Molly E. Samuelson Molly E. Samuelson Jan. 21, 2000 4;; All Copy, Town, or Location of Death County Open Street and number) Glen Burnie Anne Arundel | | 1 December 10 Name (F) A Address | and) | Cer | tificate of | Death | | Reg. No. | | 3. Time of Death |
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| 25. Was case referred to medical axaminer? 1 | | Parairia | - Ann | a ici | | | | | ava | re autopsy findings allable prior to |
| 25. Was case referred to medical axaminer? 1 | | 1 evra a ev | - MINEN | 74-0 | | | | | of c | mpletion of cause death? |
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| Gary W Jones MD POBOX 385 Laurel Md 20725-6385 | - | 30. Name and address of person who | | leath (Item 23a) (Type | Print) | | | | | |
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| 31. Date filled (Mortin, Day, Year) 32. Registrar's Signature | | | | | | | | | | |

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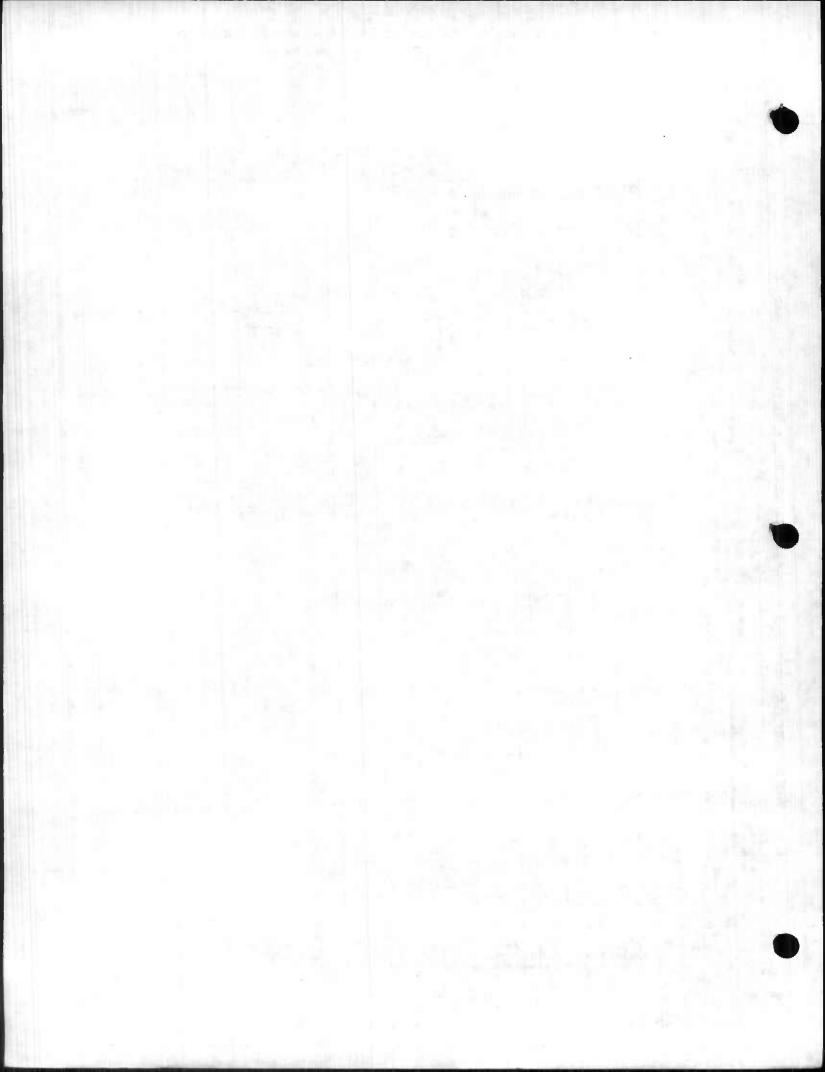
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State of Maryland / Department of Health and Mental Hygiene

ASD

| SP | | | | | | C | ertif | icate of | Death | | | Reg. No | | | |
|--|-----|---|------------|-----------------------------------|---|------------------|---------|--------------------------------------|-----------------------------|------------------------|---------------------------------|------------|--------------------|----------------------------|----------------------------|
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| Physician Medical/ | - | RIKKI LEA S | SMI | TH | | | | | | | JANUA | RY De | y 24 | 2000 | 0405 |
| /wedical Examiner | | 4a Fscility Neme (If not institution | | | m <i>ber)</i> | | | | 4b. City, To | wn, or L | ocation of Deal | - | | of Death | 0105 |
| | | 25 BROOKEBUE | RY | DRIVE | | | | | REIST | ERST | NWO. | 1 | BALT | IMORE | |
| uneral | 1 | 5. Sociel Security Number | 6. Sax | | 7. Age (In y | rs. last birthda | | Undar 1 Yaar | If Under Hours | 24 Hrs. Min. | 8. Dete of Bi (Month, Di | rth | 3 11 | 9. Birthpl Count | ace (State or For |
| rector | 1 | 552.87.8903 | 1 | M 20 F | 14 | Yrs. | | Orania Doya | 110013 | 707101. | 10-22 | - 85 | | | "CA |
| | - | Usuat Residence of Decedent | | | 140- | 04. 7 | 1 | | | | | | | | A 10-14-00-11 |
| ahoy in | a L | 10a. State 10b. County | | _ | | City, Town or | | | | | | | | 10 | Od. Inside City Li |
| or 28a-f be notifie Directo | - | MD BALTI | nok | E | K | ISTERS | | | | | | | | | |
| must be notified at erai Director | 5 | 10e. Street and Number | | | 11 | | 1 | 10f. Zip Code | 7. | | | 10g. Cit | | Vhat Count | iry? |
| ral ral | | 25 BROOKEBURY | | RIVE | " IA | | | 2113 | | | | | | ISA | |
| iner must iner must Funeral | | 11. Merital Status | | 12. Was Dec | orcas? | n U,S. 13 | If Ye | Decedent of hes, specify Cub | hispenic Or an, Mexica | igin? (Sp n, Puarto | ecify Yes or Ne Rican, etc.) | 0- | | a - America k, White, e | |
| Erame Dy F | | 1 ☑ Never Married 2 ☐ Merri 3 ☐ Widowed 4 ☐ Divorced | ed | 1 Yes If Yes, Gir Yaer or D | ve | | 10 | Yes 2 No | Specify: | | | | Specify | BLAC | 11/ |
| | | 15. Decedent | 'a Edu | | Jelas. | 16a Day | adant | 's Usuel Occup | nation | | | 16h K | ind of Bu | siness/Ind | |
| or than 'natural, the Medical I | | (Specify only highes | t grade | completed) | | (Gi | ve kind | d of work done NOT use retire | during mos | t of work | ing | 100. K | and or bu | 1311163371110 | ustry |
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| remt, 1 | 5 | 17. Father's Neme (First, Middle, | Last) | 14/7 | 1 | | | YIUULIVI | 18. Moth | ar's Nem | e (First, Middle | , Maiden | Suman | - | |
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| marks imatic To | - | KICKY L. DMIT 19a. Informant's Name/Ralations | hin (Tv | ne Print) | | 19h Ma | ilina A | Address (Street | | | | ber City | or Town | State Zin | Code) |
| 2 2 | 0 | SHARLENE SMI | 71. | | HER | P5 5 | lon | VERION | DRIV | | | | | | 0. 2113 |
| litem 27 is other tra | - | 20a. Method of Disposition | 111 | 11101 | | b. Pleca of Dis | positio | on (Name of | | | Dete | | | City or To | |
| 5 6 | | 1 Ø Buriel 2 ☐ Cremetion | | emovel from | Stete | | | ory or other pla | | 1 | 2 2000 | DAN | 00.11 | OTHILL | 1 000 |
| and a | - | 4 ☐ Donetion 5 ☐ Other (S) 21. Signeture of Funerel Service I | | 2 | K | | 00 11 | RIAL P | A FT181 | | 2.2.2000 | | | | 3, (110) |
| on a | | 21. Signeture of Purieter Service I | LICHISE | | | | JAUC | SHN C. | GREEN | JE F | | | | | |
| | 1 | 23a. Pert1. Enter the disease, or shock, or heart failure. List | | C & | - | 5 | 151 | BALTO. 1 | VATI | PIKE | BALTE |) M | 0. 21 | 229 | |
| in and rial-transit Examiner | | Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | 7 b |), | Due to | o (or es e cons | equen | nce of): | | | | ī | | | |
| s the burner edical | 1 | cause (Disease or injury that initiated events resulting in death) Last | С | , | Dua to | o (or as a cons | equan | ce of): | | | - | | | | |
| use s | | | d | | | | | | | | | | | | |
| od for | | Part II. Other significant condition | ns con | tributing to d | eath but not | resulting in the | unde | rtying cause gi | ven in Pert | l, | 23b. Did | tobacco | una co | ntributa to | the cause of d |
| F . 9 | | | | | | | | | | | 1 | Yaa 2 | E No | 3 □ Prot | ably 4 Uni |
| bengis d be det | | | | | | | | | | | | | | | |
| ahould t | | | | | | | | | | | 24a. We | s an euto | psy | avi | re autopsy findi |
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| age 2 | | | | | | | | | | | 1,2 | Yes 2 | □ No | 1,4 | Yas 2 No |
| s certificate he director, page To Be Com | | 25. Was case referred to medical | | | | | | | 26. Plac | e of Deal | th (Check only | one) | | | |
| I direc | | exeminer? 1 ☑ Yes 2 ☐ No | Н | ospitel: | Inpatient 2 | 2 ER/Outpat | ient : | 3 DOA O | her _ | ursing Ho | | | 6 DOth | er (Specify | () |
| eraldi n: To | | 27. Menner of Deeth | | | of Injury Day Year | | of. | 28c. Inju Wo | | | 28d. Describe | | | | 1 |
| al Director: After to led in by the funeral Certification: | | 1 □ Neturel 5 □ Pendin 2 □ Accident investig | g ation | Found | 4-00 | Fusinjun | A | | Yes 2/ | No | subject | t ha | inger | 1 selj | |
| by the | | 3 Suicide 6 □ Could r 4 □ Homicide determ | not be | 28e. Pleca | a of Injury - A | t home, ferm, | street, | fectory, office | | | 281. Location | (Street el | nd Numb | per or Rura | Route Number |
| E E | | 4 Homicide | | DUIIG | ing, etc. (Sp | ha ha | 70 | | | | Renders | | M.S. | Greeke l | ung Drive |
| 27. Menner of Deeth 1 Neturel 2 Accident 3 Suicide 4 Homicide 29e. Certifler (Check only one) 29e. Signature end title of certifier | | | | er: On the b | e best of my leasis of exeminer steted. | knowledge, de | eth oc | curred et the ti igation, in my o | me, dete ar opinion, dee | nd plece, eth occur | end due to the | ceuse(s | and me d place, | enner as st and due to | ated. the cause(s) |
| To the | | 29b. Signature end title of certifier | | | | | | 29c. Licens | se number | | | 29d. Da | ate signe | d (Month, | Day, Year) |
| | | A Barrers | 1 / | huten | | | | o.c. | M.E | | | JAN | JARY | 24. | 2000 |
|) | 1 | 30. Nama and address of person | who co | 0000 | | Item 23a) (Typ | e, Prin | 1 | | | | | | | _ 0 0 0 |
| 3 | | Dennis J. Ch | 14-10 | 100 | 3=0(| | | | nn St | reet | , Balt | imore | e, M | aryla | nd 2120 |
| State | | 31. Date filed (Month, Day, Year) | Nell | 32. F | Registrar's Si | gnetura | | | | | | | | | |
| Registrar | | JAN 2 8 2000 | | 50 | 1 | , , | as h | 1. | | | | | | | |
| | | UHIY G O CUUU | | 1- The | | 40 | ack | 2 | | | | | | | |

DHMH 16 Rav 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienen Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death YAN N Year 6:52 AH 2000 HAROLD STALLINGS 4b. City, Town, or Location of Death 4e Facility Name (If not institution, give street and number) 4c. County of Death YOHN SHOPKINS HOSPITAL BALTIMONE If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, Sept 19 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Months Days Hours 62 YIS. 1⊠M 2□ F Maryland 215-34-9965 Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Carroll Mt. Airy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2951 Gillis Falls Road 21771 USA 12. Wes Decedent Ever in U.S. Armed Forces? 1 ⊠ Yes 2 □ No 955 − Year or Dates: 1957 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married specify: White 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Heating & Air Conditioning Federal Government 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Oliver Stallings Nellie A. Ellison 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) Joanne R. Stallings (spouse) 2951 Gillis Falls Rd. Mt. Airy, MD. 21771 20b. Place of Disposition (Name of cometery, cremetory or other place) 20a. Method of Disposition Jane 27 20c. Location - City or Town, Stata 1 D'Burial 2 Cremation 3 Removel from State Crestlawn Cemetery 2000 Marriottsville, MD. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Literature 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD. 21122 23a. Pert1. Enter the disease, or bomplidations that caused the chall. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heer failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finel disease or condition resulting in deeth) PNEUHOTHORAX UNICNIOUN Due to (or as a consequence of): NOW - SMALL CELL CANCER 34FANS LUNG Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that inflieted events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 20 No 25. Wes case referred to medical axaminer? 26. Place of Death (Check only one) Hospital: 1) Inpatient 2 ER/Outpatient 3 DOA 1 Yes No Other: 4 Nursing Home 5 Pesidence 6 Other (Specify)

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

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28a-f

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natural, or I

filed within 72 hours after

Pages 1 and 2 should be nent of Health and Mental

Department of Health ar Important: if item 27 is any injury or other trau

Baltimore, Maryland 21215-0020

Directo

Funeral

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Completed

Be

Examiner Physician/Medical à Completed Be

ician and burial-transit Medical Certification: To

The law requires that the death certificate be executed or Attending Physician: after deat Director: 24 hours a

SIA Lings [forcolo] Division of Vital Records, P.O. Box 68760,

within 2

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State Registrar

DHMH 16 Rev 6/95

MAKOYMIZIAN

27. Menper of Death

1 Matural

2 Accident

3 Sulcide

29a. Certifier (Check only one)

4 Homicide

H O

29c. License number 5 6 521 A

28c. Injury at Work?

1 Yes 2 No

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) YAN. 24 2000

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

CATON AVE, BALTIMORE, MP

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KAWALISC 500 MD

28a. Date of Injury (Month, Day Year)

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

JAN 28 2000

5 Pending

Investigation

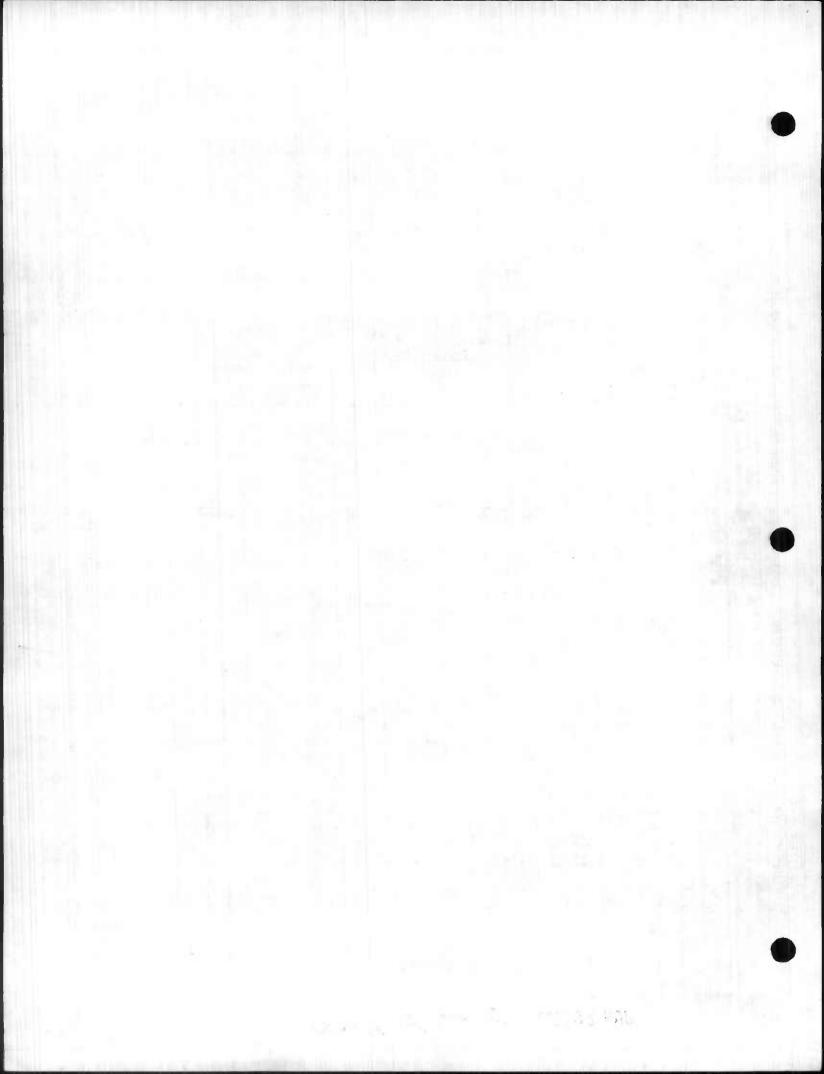
6 Could not be determined

32. Registrar's Signature

Sparker

28b. Time of

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)



Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician Robert Beam Sheppard** JANVAR 2000 /Medical 4a Facility Name (II not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner AG MES BALTIMORE. HOSPITAL **Baltimore City** If Under 1 Year | If Under 24 Hrs. | 8. Data of Birth (Month, Days Hours | Min. | (Month, Day, Year) Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Aga (In yrs. last birthday) **Funeral** 1 XM 2 F 73 Yrs. December 16, 1926 Director 215-22-4865 Usual Rasidenca of Decedant 10c. City, Town or Location 10d. Inside City Limits 10a. Stata 10b. County 1 Yas 25 No the Medical Examiner must be notified Director Maryland **Baltimore** Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 21228 U.S.A Name 23a 1308 Pleasant Valley Drive Funeral 12. Was Decedant Ever in U,S. Amed Forces? 1'50 Yas 2 □ No IVas, Giva Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - American Indian, 11. Merital Stetus Black, Whita, etc. 1 Nevar Married 2 Married 1 Yas 2 No Specify: b 1944 Baltimore, Maryland 21215-0020 Specify: White à 3 ☐ Widowed 4 ☐ Divorced 1946 "natural" Completed 15. Decedent's Education (Specify only highast grada completed) 16a. Decedent's Usuel Occupation 16b. Kind of Business/Industry (Giva kind of work dona during most of working life. DO NOT use retired) Hygiene. Construction Elementary/Secondary (0-12) Collega (1-4or 5+) carpenter 12 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middle, Meiden Sumema) Be pernit. Pages 1 and 2 should be in Department of Heath and Mental Important: If Item 27 is marked of any injury or other traumatic eve Walter C. Sheppard Nellie Mae Beam 19b. Malling Address (Street end Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) 1308 Pleasant Valley Drive Catonsville, Maryland 21228 Mrs. Sylvia C. "Bettye" Sheppard 20b. Place of Disposition (Nama of cametery, crematory or other place) All County Cremation Services, Inc. 01/26/2000 20a. Mathod of Disposition 20c. Location - City or Town, State 1 Burial 2 Cramation 3 Ramovel from Stata 4 Donetion 5 Othar (Specify) Sykesville, Maryland 21. Signature of Funerel Service Licenses 22. Nama and Addrass of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 M01204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate tntarval Between Onset and Death **Physician** Immediata Ceusa (Final disaasa or condition rasulting In death) /Medical Examiner Examiner physician and the buriel-transit Sequantially list conditions, if any, leeding to Immadiate cause. Entar Undarfying Cause (Disaase or injury that initiated events rasulting In death) Last of Vital Records, P.O. Box 68760 Physician/Medical Sheppard, Robert 23b. Did tobacco use contribute to the cause of death? Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Aq 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed 1 Yas 2 No 1 ☐ Yas 2 No 25. Was casa rafarred to medical axaminer? Be 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yas 2 No 10 1∑Inpatient 2□ ER/Outpatient 3□ DOA 28b. Tima of Injury 27. Mannar of Death 28a. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred 28c. Injury at Work? Affer 5 Pending Invastigation 1 Natural death. 1 Yes 2 No 2 Accidant 24 hours after deatl Puneral Director: 6 Could not be 28e. Plece of Injury - At homa, farm, street, factory, office building, atc. (Specify) 3 Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 4 Homleide 29e. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of axaminetion and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. Medical within 2 29b. Signatura and titla of certifiar 29c. License number 29d. Data signed (Month, Day, Year) OBENG M.D 30. Name and address of person who completed causa of daeth (Item 23a) (Type, Print) HOSPITAL. 900 CATON AVE. BALTIMORE. MD. 32. Registrar's Signeture 31. Dete filed (Month, Day, Year)

State Registrar

DHMH 16 Ray 6/95

Beneva G. Sports

Piease Type or Print in Biack indelibie ink. Assure Ail Copies Are Legibie. State of Maryland / Department of Health and Mental Hygiene | Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2:00 **Physician** CMes trank lowner 22 2000 Jan. am /Medical 4c. County of Death 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Balt 7. Age (In yrs. last birthday) emoria IMORE If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) (000/100 5. Social Security Number **Funeral** Days 10 M 20 F 217-18-397 Yrs. Director Usual Residence of Decedent deeth with the Meryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits - Phow 1ETYes 2□No Funeral Director More 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number mast be lar/es 12. Was Decedent Ever in U,S. Armed Forces? 12 Dyes 2 No If Yes, Give 1-19-42 Year or Dates: 11-17-44 tems! Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours efter ment of Heelih and Mentel Hyglene.

Intel if Nem 27 Is marked other than "natural", or he lay or other than the world event, the find of 1 Never Married 2 Married 21215-0020 1 ☐ Yes 2 ☐ XNo Specify: Black by 11-17-45 3 ☐ Widowed 41 ☐ Divorced Completed 16a. Decedent's Usuat Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) t/1 Vet Baltimore, Maryland Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be WAlton lownes 1160 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Randalktown Drelland tortune. seman 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date cemetery, crematory or other place; 1 Burial 2 Cremation 3 Removal from State Department of Important: If eny injury or other. 1-28-00 Dwings Mils, 4 ☐ Donation 5 ☐ Other (Specify) lemeter 1 22. Name and Address of Facility Left Miller P.C. Funeral 21. Signature of Funeral Service Licensee Home & Services Jeff Miller 1639 North Brockeray 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest shock, or not failure. List only one cause on each line. **Physician** Immediate Cause (Final /Medical 1-2 Hours neunous disease or condition resulting in death) Examiner Due to (or es a consequence of) The law requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Due to (or as a consequence of): for use Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributa to the cause of death? Records, P.O. 3 Probably 4 Onknown 1 Yas 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate Division of VItal or Attending Physicien: 8 25. Was case referred to medical 26. Plece of Death (Check only one) axaminer? 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 8 Other (Specify) Certification: To 2 ER/Outpatient 3 DOA 1 Inpatient 100 28a. Date of Injury (Month, Day Year) 27. Mannet of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Affer 1 Matural 5 Pending s efter deeth. 1 Yes 2 No 2 Accident investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital or Within 24 hours of To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier completely (Check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 017537 1-27-2-000 30. Name and address of person who completed cause of death (Negri 23a) (Type, Print)

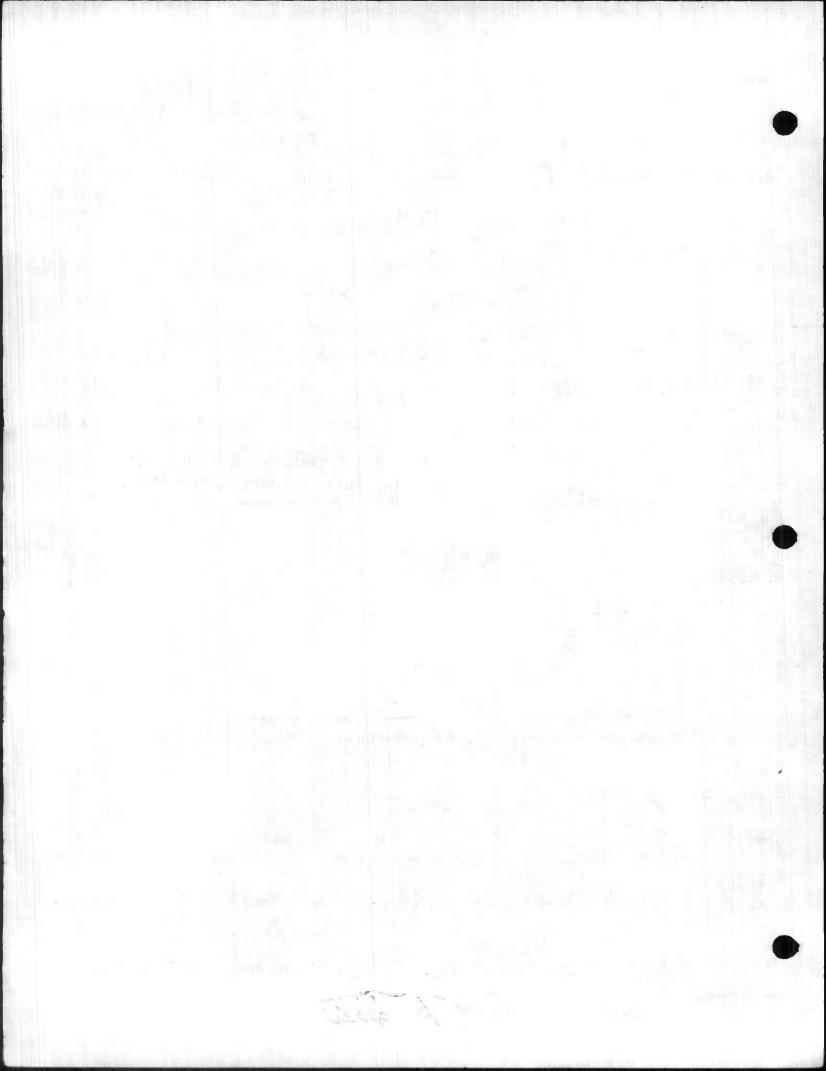
DALSHAM. S. SALUINM) (600 W. MOUNT ROYAL Are, BALTIMORE a 21217 32 Registrar's Signature 31. Date filed (Month, Day, Year)

DHMH 16 Rev 6/95

State

Registrar

JAN 2 8 2000



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene \(\) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Month Year PAUL TINKER 25 2000 07:00AM JANUARY 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death THE JOHNS HOPKINS HOSPITAL BALTIMORE CITY If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Months Days 1 M 2 □ F Hours 64 Yrs. 3-26-1935 212-30-6983 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Yes 2 No Pennsylvania Delta 10e Street and Number 10f. Zin Code 10g. Citizen of What Country? 157 High Ridge Road 17314 U. S. A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Dates 1957—1959 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 1 ☐ Never Merried 2 ☑ Merried 1□ Yes 2□ No Specify: Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Project Manager 12 Johns Hopkins Univ. 17 Father's Name (First Middle Lest) 18. Mother's Name (First, Middle, Maiden Sumeme) Robert J. Tinker Ida Legg 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mrs Jane Tinker (Wife) 157 High Ridge Road, Delta, Pennsylvania 17314 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Mem. Gards. 1-29-00 Timonium, Maryland 21. Signature of Funeral Service Licansee 22. Name and Address of Facility Wallace Ruck Towson Funeral Home, Inc. 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sepsis 4 DRYS Due to (or as e consequence of) erforated Duodena Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of 2 YEARS CANCERTIC CANCER Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? 1 Yas 2 No 3 Probably 4 Unknown Acute Renal FAILURE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 25 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Homa 5 Residence 8 Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 ANaturel 2 Accident 5 Pending investigation 1 Yes 2 No 6 Could not be 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 🔟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated. (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and placa, and dua to the cause(s) and menner steted.

Box 68760. Records, P.O.

physician and the burial-transit signed by t 988 Division of Vital this To the Hospital or Attending Pi within 24 hours after death. To the Funeral Director: After it completely filled in by the funera After

Physician

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permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygien Importants if them 27 is marked other the any Injury or other treasments

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To

Medical Certification:

Baltimore, Maryland 21215-0020

must be notified at

Directo

Funeral

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State

Registrar

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print) JAcobsen D 31. Dete filed (Month, Dey, Year)

29b. Signeture end title of certifier

JAN 28 2000

ERIC

M.D. 32. Registrar's Signature

MD

600 NORTH WOLFE STREET BALTDMORK MARYLAND 21205

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

JANUARY 25, 2000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U Certificate of Death 1. Decedant's Name (First, Middle, Last) 2. Data of Death 3. Time of Death Year Month January 20, 2000

4b. City, Town, or Location of Death 4c. County of Death Doris M. Taylor 7:00 P.M. 4a Facility Neme (If not institution, give street and number) Pasadena If Undar 24 Hrs. 7767 Tick Neck Road Anne Arundel If Under 1 Yaer 5. Social Security Number 8. Deta of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Days Months Hours 1 ☐ M 2 🛣 F Yrs. 216-14-3786 Aug. 31, 1923 Maryland Usuel Rasidence of Decedant 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas 2 54 No Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7767 Tick Neck Road U_S_A_ 14. Race - American Indien, Black, Whita, atc. 21122 12. Was Decedent Ever in U.S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puerto Rican, etc.) 11 Marital Status 1 ☐ Yas 2 ☑ No If Yas, Giva 1 Nevar Marriad 2 Married 1 ☐ Yas 2 ☑ No Specify Specify 3 ☐ Widowed 4 ☐ Divorced Yaar or Datas White 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) College (1-4or 5+) 12 Earnings Scout N/A Social Security Admin. 17. Fether's Nema (First, Middle, Last) 18. Mothar's Name (First, Middle, Maiden Sumama) Holley Lena Conaway 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Joseph E. Taylor (Husband) 7767 Tick Neck Road Pasadena, Maryland 21122 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cematery, crematory or other place) Data 20c. Location - City or Town, State 1 ■ Burial 2 □ Cremetion 3 □ Removel from Steta 4 ☐ Donetion 5 ☐ Othar (Specify) Glen Haven Memorial Park 1/24/00 Glen Burnie, Maryland 21. Signature of Funaçal Sarvice Licensee 22. Nama and Address of Facility McCully-Polyniak Funeral Home, P.A. 23a. Part 1. Effect the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest,

Approximate shock, or heart failure. List only one cause on each line. MULTIPLE DAYELOMA Immediata Causa (Final disaesa or condition rasulting in daath) Due to (or as a consequence of) Sequentially list conditions, if any, laading to immadiate cause. Enter Undarlying Causa (Disaase or injury that initieted events resulting in death) Last Dua to (or as a consequence of): Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part ii. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part i. 1 Yee ANO 3 Probably 4 Unknown 24b. Ware autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 21 No 1 ☐ Yas 2 ☐ No 25. Was casa rafarred to medical 26. Placa of Death (Check only ona) Other: 4 Nursing Homa SA Residence 8 Other (Specify) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 20 No 26a. Data of Injury (Month, Dey Year) 27. Mangar of Death 28b. Tima of 28c. tnjury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yas 2 ☐ No investigation 2 Accident

Box 68760. certificate be P.O. Records.

and physician as the buriel Physician/Medical 987 2 bengis d be def þ Completed peed certificate Be Certification: To this After death.

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/Medical

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Department of Health and Abrillat Hy Important: If Item 27 is marked other any Injury or other to

Physician

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Examiner

altimore, Maryland 21215-0020

Division of Vital or Attending Physician: Director: after 24 hours after Funeral Dire letely filled in b To the Hospital of within 24 hours a To the Funeral D

State

DHMH 16 Rev 6/95

Registrar

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31. Data filed (Month, Day, Year) JAN 2 8 2000

29b. Signature and title of certifie

3 ☐ Suicida

29a. Cartifian

4 ☐ Homicida

(Check only one)

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6 Could not be determined

32. Registrar's Signatura

30. Nama and address of person who completed cause of death (Item 23e) (Type, Print)

Um

BESTEATE NO

28e. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify)

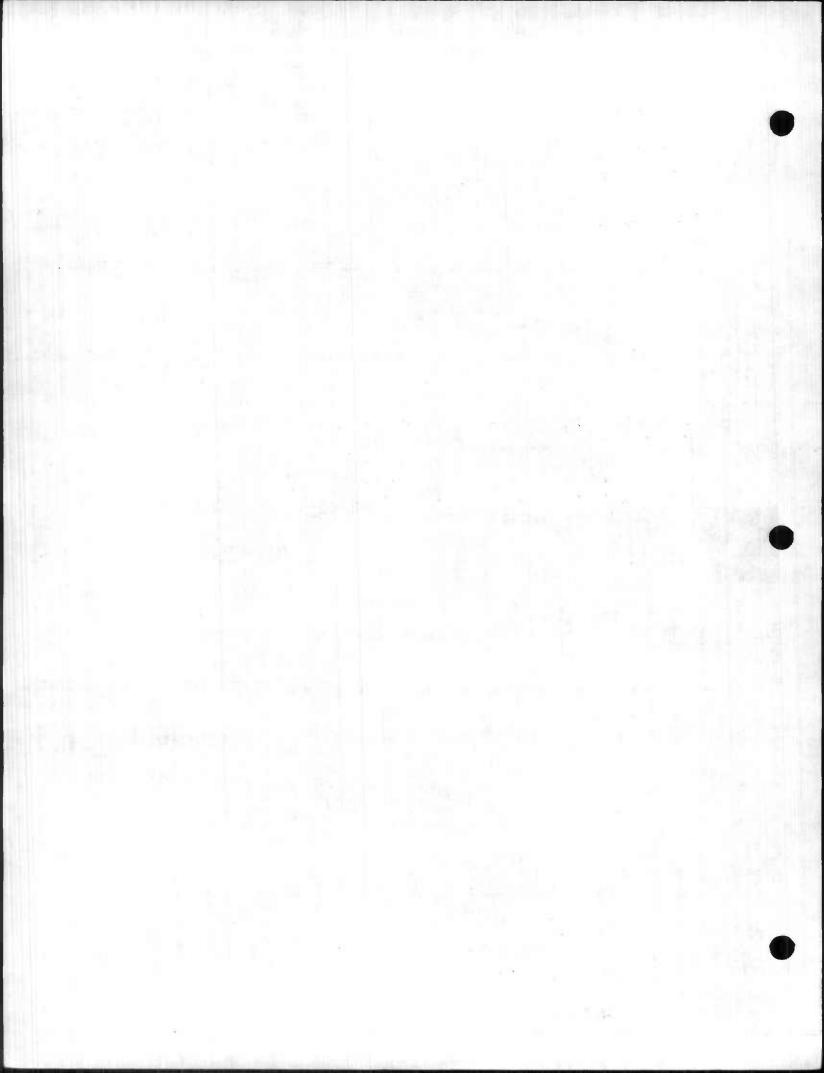
🖄 Certifying Physician: To the best of my knowledge, deeth occurred at tha time, date and place, and dua to tha cause(s) and mannar as stated. 2 Medical Examiner: On the basis of axamination end/or investigetion, in my opinion, death occurred at the time, date and place, end due to the cause(s) and mapner stated.

29c. License number

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29d. Data/signed (Month, Day, Year)

21/00



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent'a Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Month Year **Physician** 25, Elmer Forrest Tramontina JANUARY 2000 2:00 AM /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Saint Joseph Medical Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. 8. Data of Birth (Month, Day, Year)
July 18, 1914

8. Birthplaca (Stata or Foreign Country)
West Virginia 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 1 M 2 □ F Yrs. 85 Director 216-01-3780 Usual Rasidence of Decedent The Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas 2 No Directo Baltimore 28a-f Lutherville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 30 Margate Road 21093 U.S.A. Funeral llams. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, 11. Marital Status 12. Was Decedent Evar in U,S. Armed Forces? Black, Whita, atc. Pages 1 and 2 should be filed within 72 hours after trent of Health and Mental Hygiene.

Intel 87 is marked other than "netural", or its any or other treumatic event, the Medical Examins I XYas 2 ☐ No If Yas, Giva 1 Never Married 2 Married altimore, Maryland 21215-0020 1 Yas 2 No Specify: Specify: ğ 3 Widowed 4 Divorced White Year or Datas: WWII Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) 9 Painter Belsinger Sign Co. 17. Father's Name /First, Middle, Last) 18 Mother's Nama (First, Middle, Maidan Surnama) Be Fred Tramontina Ethel Jordan 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant'a Name/Ralationship (Type, Print) Mrs. Janet Tramontina/Wife 30 Margate Road Lutherville, Maryland 21093 20a. Mathod of Disposition 20b. Place of Disposition (Nama of Data 20c. Location - City or Town, Stata cematary, crematory or other place) 1 Burial 2 Carmation 3 Ramoval from Stata Department of Important: If any injury or 4 ☐ Donation 5 ☐ Othar (Specify) Hilltop Service Corp. 1/28/2000 Towson, Maryland 21. Signeture of Funaral Sarvice Litenses 22. Nama and Addrass of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Part1. Entar the disaase, or shock, or haert failura. Ust complications that caused the death. Do not anter the mode of dying, such as cardiac or respiretory arrest, only one cause on each line. Approximate Interval Batween Onset and Death **Physician** RECURRENT ASPIRATION PNEUMONIA /Medical Immediate Cause (Final diseasa or condition rasulting in death) Examiner Due to (or as a consequence of) Examiner The law requires that the death certificate be executed the burial-transit Sequentially list conditions, if any, laading to immediate cause. Enter Undarlying Cause (Disease or injury that initiated evants rasulting in death) Last and Dua to (or as a consequence of) Box 68760, Physician/Medical Dua to (or as a consequence of) USe as signed by the atte Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. P.0. 23b. Did tobacco use contribute to the cause of death? 1 Yaa 2 No 3 Probably 4 Unknown SEVERE KYPHOSCOLIOSIS Completed by Records, 24b. Wara autopsy findings available prior to completion of causa of death? 24a. Was an autopsy parlormed? should page 2 SBC. 2 No 1 Yas 20 No certificate 1 Yas Division of Vital or Attending Physician: funeral director. Be 25. Was casa referred to medical axaminar? 26. Placa of Death (Check only one) Hospital: 1 topatient 2 ER/Outpatient 3 DOA Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1 Yas 2 No Medical Certification: To After this 27. Manner of Death 1 Denatural 28a. Data of Injury (Month, Day Year) 28b. Tima of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending after death. Director: Af 1 Yas 2 No invastigation 2 Accident 6 Could not be datarmined 3 Suicide 28e. Place of Injury - At home, farm, street, fectory, office building, atc. (Specify) 281. Location (Street and Number or Rural Routa Number, City or Town, Stata) filled in by 4 Homicide 24 hours a Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at tha tima, data and place, and dua to tha causa(s) and mannar es stated completely (Check only one) 2 Medical Examiner: On the basis of axaminetion and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner stated. To the To the To the I 29c. License number 29d. Data signed (Month, Day, Year) 29b. Signatura and titla of certified D 37254 00 25 30. Nama and address of parson who completed causa of death (Item 23a) (Type, Print)

DHMH 16 Rev 6/95

State Registrar

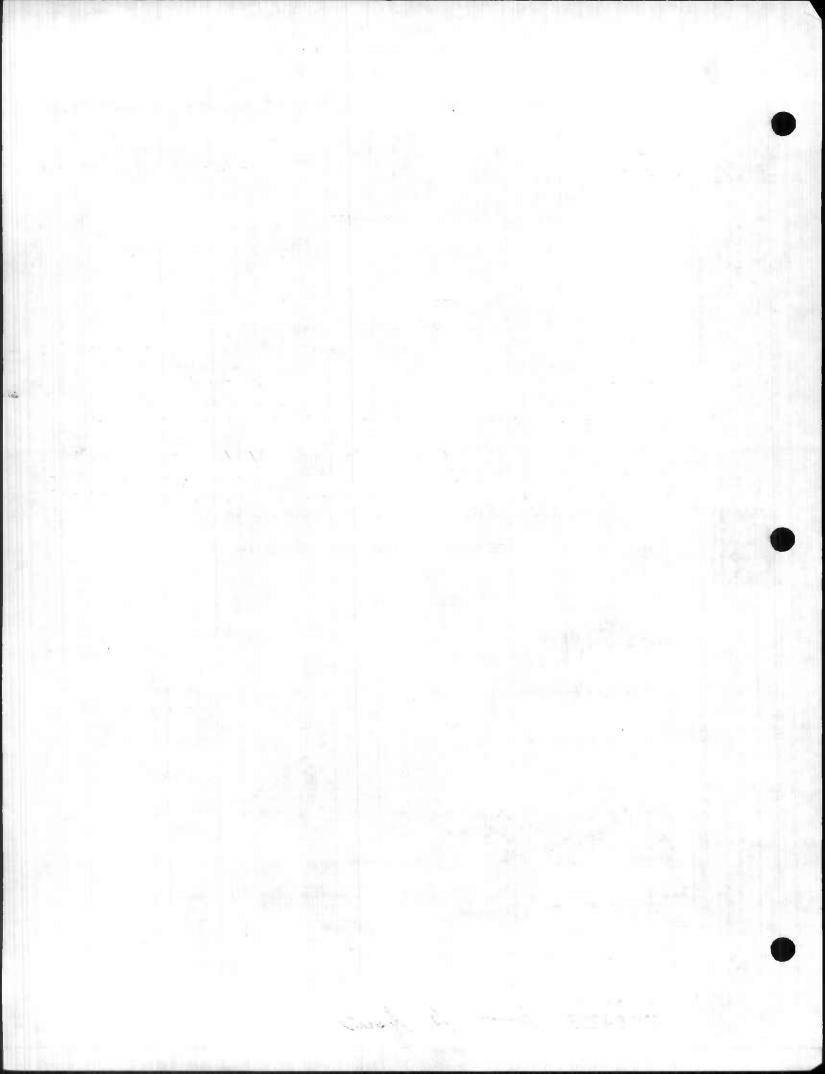
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BOON P. LIM M.D.

32. Registrar's Signatura

Sparky

7601 OSLER DRIVE, TOWSON, MARYLAND 21204



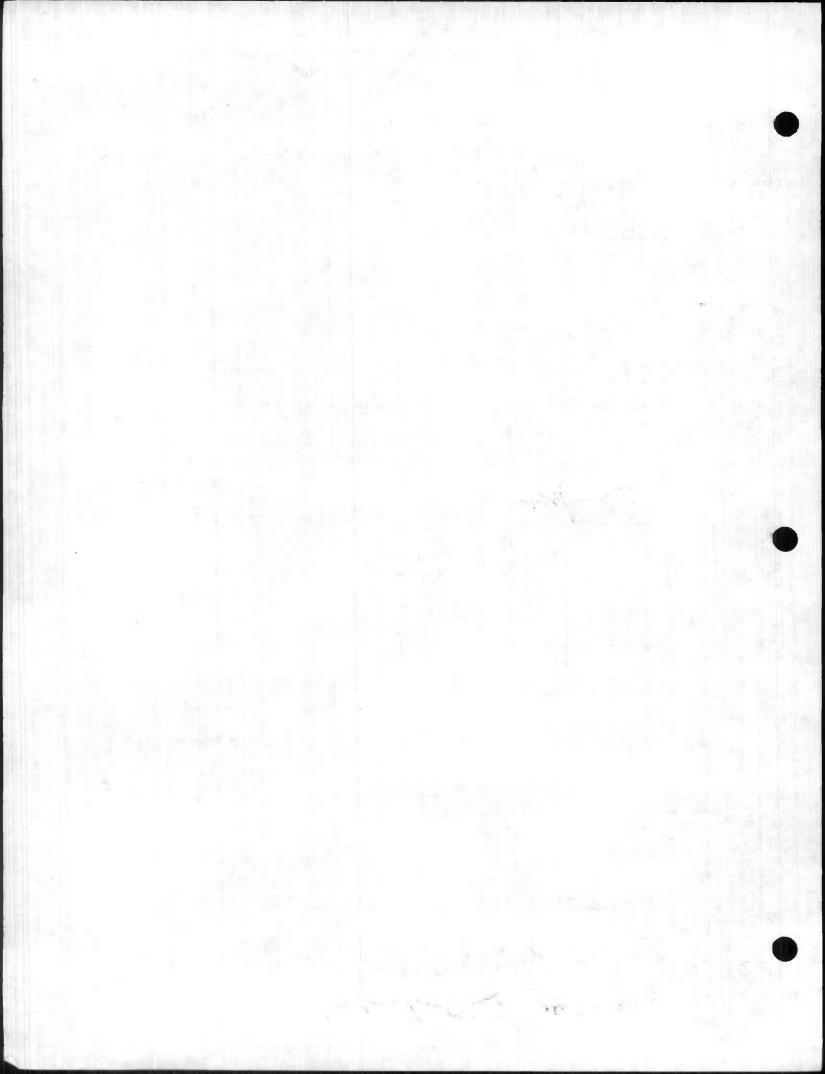
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| 4a Fscility Name (If not in JOHNS HOPKI | | | 9r) | | | 4b. City, Town BALT | | on of Death | 4c. County | N/A | | |
| 5. Social Security Number 103-56-0911 | | 9X 7. / | Age (In yrs. 25 | last birthday) Yrs. | If Under 1 Year Months Days | | | Dete of Birth Month, Day, | 9. Bir 1974 New | | tace (State or Foreig | |
| Usual Residence of Deced | dent County | | 10c. Cit | y, Town or Lo | ocation | | | | | . 1 | 0d. Inside City Limit | |
| | N/A | | | Balti | | | | | | | XXYes 2□N | |
| 10e. Street and Number | | | | | 10f. Zip Code | | | 10 | g. Citizen of | What Coun | itry? | |
| 1531 E. Monu | ment | | | | 21205 | | | | USA | | | |
| 11. Merital Stetus Never Merried 2 3 Widowed 4 D | | 12. Wes Deceder Armed Force 1 Yes 28 If Yes, Give Year or Date: | No | If Yes, specify Cuban, Mexican, Pu | | | | n? (Specify Yes or No- Puerto Rican, etc.) 14. Rac Ble Specif | | | | |
| 15. Do | ecedent's Ed | ucation de completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use retired) | | | of working | 1 | 6b. Kind of B | usiness/Inc | dustry | |
| Elementery/Secondary | | College (1-40 | or 5+) | Waite | | | To To | lestaur | com t | | | |
| 7. Father's Neme (First, I | Middle, Last) | | | Walt | -L | 18. Mother's | s Name (Fil | | laiden Sumen | | | |
| Kenrick A. Tull Sr. Lora Bell Roberts | | | | | | | s | and the same of th | | | | |
| 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State 1531 E. Monument St. #2 Balto., Md. 21: | | | | | | | | | | | | |
| Lora Tull (1 20a. Method of Disposition | |) | 20h P | | E. Monun | ment St | - | | Oc. Location | - | | |
| 1 Buriel 2 ☐ Cren | nation 3 🗆 | | 10 | emetery, cre | metory or other ple | | | | | | | |
| Voshell's Mem. Gardens 1/28/2000 Dundalk, Maryland 21. Signature of Force Service Densee 22. Name and Address of Fecility Caple Funeral Service | | | | | | | | | | | | |
| 1 The | 1 6 | 1 | / | 5 | 502 Winne | - A | | | | | 9 | |
| Immediate Cause (Final disease or condition | | 1 | 4 / | 2 .1 | | | | | | | | |
| resulting in death) | | a. Ulu | | or es a conse | | | | | | | | |
| resulting in death) Sequentially list condition fany, leading to immedia cause. Enter Underlying Cause (Disease or trijury hat initiated events | s, te | a | Due to (o | STATE TO 1 | quence of): | | | | | | | |
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| resulting in death) Sequentially list condition if any, leading to immedia cause. Enter Underlying Cause (Disease or trijury that initiated events resulting in death) Last | ι | b | Due to (o | or es a conse or es e conse or as a consec | quence of): | ven in Part I. | | | a 2 No | 3 Prof | ere autopsy findings allable prior to impletion of cause | |
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| resulting in death) Sequentially list condition if any, leading to immedia cause. Enter Underlying Cause (Disease or trijury that initiated events resulting in death) Last | medical | b | Due to (o | or es a conse or es e conse or as a consec | quence of): quence of): quence of): underlying cause gi | 26. Place o | | 1 Ye 24a. Was ar perform 1 XYe | a 2 No n autopsy ned? | 3 Pro | ere autopsy findings allable prior to mpletion of cause death? | |
| Sequentially list condition if any, leading to immedia cause. Enter Underlying Cause (Disease or trijury that initiated events resulting in death) Last Part II. Other eignificant of examiner? XXYes 2 \(\subseteq \) No 27. Manner of Death 1 \(\subseteq \) Natural 5 \(\subseteq \) 2 \(\subseteq \) Accident | medical Pending | b c d portributing to death | Due to (o Due to (o Due to (o but not resi | or es a conse | quence of): quenc | 26. Place c her: 4 □ Nurs | eing Home 28d | 1 Ye 24a. Was ar perform 1 Ye heck only one 5 Reside. Describe ho | n autopsy ned? s 2 No N | 3 Proi | ere autopsy findings aliable prior to mpletion of cause death? Yes 2 No | |
| Sequentially list condition if any, leading to immedia cause. Enter Underlying Cause (Disease or trijury that initiated events resulting in death) Last Part II. Other efgnificant of examiner? XYes 2 \(\subseteq \) No 27. Menner of Death 140 Natural 5 \(\subseteq \) Accident | medical Pending | b c d portributing to death Hospital: 1 inpa 28a. Date of in (Month, i) 28e. Place of | Due to (o Due to (o Due to (o Due to (o n but not resident 2%) atient 2% njury Dey Year) | or es a consecutiva as | quence of): quenc | 26. Place of ther: 4 \(\text{Nurs} \) Nurs 1/4 \(\text{Nurs} \) 1/4 \(\text{Nurs} \) 1/4 \(\text{Nurs} \) | eing Home 28d | 1 Ye 24a. Was ar perform 1 Ye heck only one 5 Reside. Describe ho | n autopsy ned? s 2 No s 2 No s) nce 6 Ott w injury occur | 3 Proi | ere autopsy findings allable prior to mpletion of cause death? | |
| Sequentially list condition if any, leading to immedia cause. Enter Underlying Cause (Disease of trijury that initiated events resulting in death) Last Part II. Other significant of examiner? XXYes 2 No 27. Manner of Death 1 Natural 5 2 Accident 3 Suicide 6 4 Homicide | medical Pending Investigation Could not be determined | d | Due to (o Due to (o | PR/Outpatie 28b. Time c Injury wiedge, deat | quence of): quence of): quence of): quence of): anderlying cause given the second | 26. Place of her: 4 \(\text{Nurs} \) Nurs at m/r? Yes 2 \(\text{Nurs} \) | 28d. 28f. | 1 Ye 24a. Was ar perform 1 Ye heck only one 5 Reside Describe ho Location (Str. City or Town | nautopsy ned? s 2 No | 3 Proid 24b. W. av co of of 1 proid anner (Specific rred | ere autopsy findings allable prior to mpletion of cause death? Yes 2 No Ny) Plante Number, stated. | |

Registrar

DHMH 16 Rev 6/95

ORIGINAL



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year TRUAX **Physician** GOLDIE GOITH 10:07 AM 4b. City, Town, or Location of Death 2000 5 /Medical 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Washington County Hospital Hagerstown Washington If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 27,1919 Birthplaca (State or Foreign Country) **Funeral** Days Hours 1 M 2 YF Yes 80 220-01-2055 Director MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director MD Washington Keedvsville or hams 23s or 28s-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3703 Chesnut Grove Road 21756 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 [] Yes 2 [X]No II Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: à 3 ☐ Widowed 4 ☐ Divorced "natural". Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry illad within 7 Hygiana. Other than "n Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home permit. Pages 1 and 2 should be the Department of Health and Mental Hy Important: If them 27 is marked other any injury or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Grover Myers Kitty Weaver 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Terrance L.Truax/Son One Hardy Court Towson, MD 21204 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Removel from State 4 □ Donation 5 □ Other (Specify) Tonoloway Baptist Cemetery 1/8/2000 Needmore, PA 21. Signature of Funeral Service License 22. Name and Address of Facility Grove Funeral Home, P.A. 141 W.Main St. Hancock, MD 21750-0368 used the death. Do not enter the mode of dying, such as cardiac or reson each line. 23a. Part1. Enter the disease, or complica shock, or heart teilure. List only one Approximete Intervel Between Onset and Deeth one enue **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical 10 VENTRICULAR FIBRILLATION Examiner Due to (or as a consequence of) Examiner ettending physician and for use as the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medicai Due to (or as a consequence of): Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy performed? 1 Yes 2 No 1 Yes No of Vitai 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpetient 25 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) To 1 Yes ZR No 計 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred I or Attending P Affer Division

DHMH 16 Rev 6/95

Registrar

filled in by the f

Medicai

Hospital 24 hours To the Hospital within 24 hours of To the Funeral Completely filled Natural

2 Accident

3 Suicide

29a. Certifier

4 T Homicide

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

5 Pending investigation

6 Could not be

Dan H. McDouga

Mc Douga

JAN 2 8 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

同れている

Medical

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

M.D.

32, Registrar's Signature

11110

1 Yes 2 No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

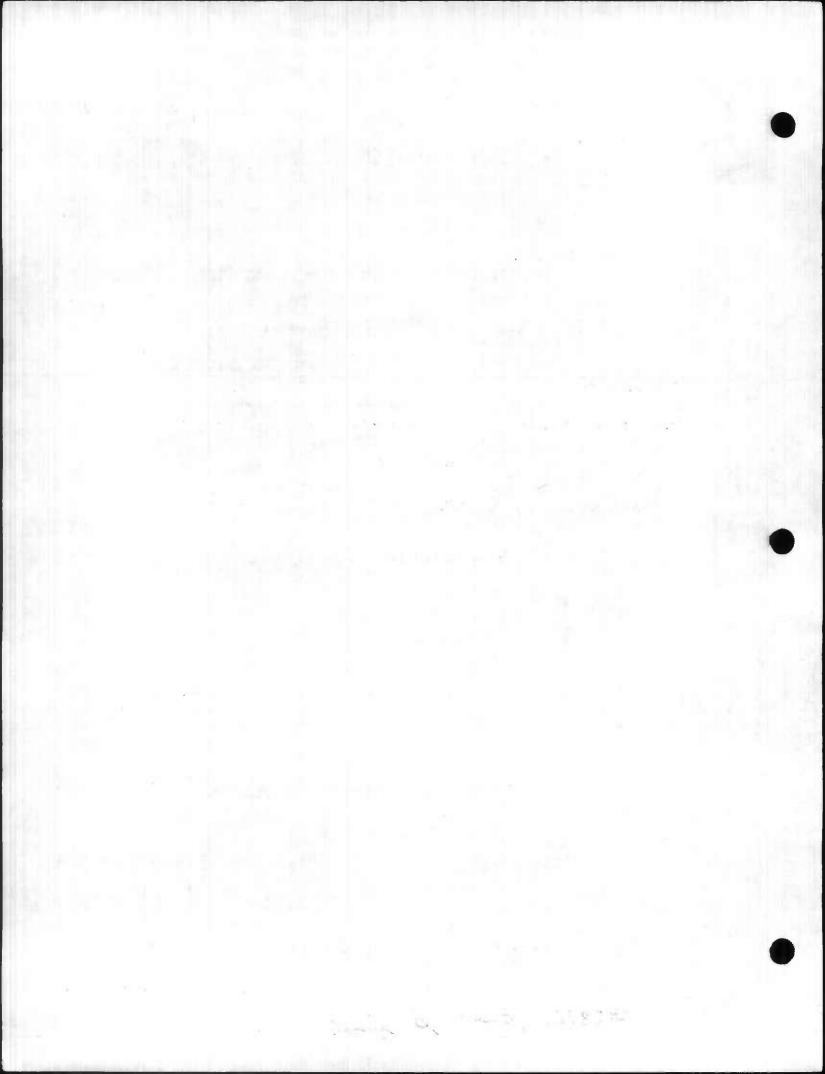
29c. License number

D21470

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Campus Rd Hag. Md. 21742

29d. Date signed (Month, Day, Year) 1/24/00



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Output Department of Health and Hygiene Output Department of Health an Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month WENDELL P. VAUGHN January 23, 2000 on 4b. City, Town, or Location of Death 4a Fecility Name (If not institution, give street end number) 4c. County of Death City General Hospital altimore aryland If Under 1 Yeer If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) Days XXM 2□ F Yrs. 214-42-8131 56 11-29-43 MD Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ty Yes 2□ No N/A BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 522 W. HOFFMAN ST. 21201 12. Wes Decedent Ever in U,S Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 11. Maritel Status 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: BLACK 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) t6b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) LABORER LANDSCAPING -9-17. Fether's Neme (First, Middle, Lest) 18. Mother's Name (First, Middle, Meiden Sumame) JAMES MANOKY GERALDINE VAUGHN 19e. Informant's Name/Relationship (Type, Print) 19b. Melling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) JOAN VAUGHN(WIFE) 522 W. HOFFMAN ST. BALTIMORE, MARYLAND 21201 20b. Piece of Disposition (Neme of cemetery, cremetory or other piece) 20e. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremetion 3 Removal from State ZION CEMETERY 2-2-2000 BALTIMORE, MARYLAND 4 Donetign 5 Other (Specify) 22. Name end Address of Facility PHILLIPS FUNERAL HOME, P.A. 21. Signatury of Funeral Service Un 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Pluft. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory arrest, shark, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Finel disease or condition resulting in deeth) Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es e consequenca of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Miknown 24b. Were autopsy findings eveileble prior to completion of ceuse of death? 24a. Wes en eutopsy performed? 2 1 No 25. Wes case referred to medical examiner? 26. Plece of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 DER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Dey Yeer) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. tnjury at Work? t DNaturat 5 Pending

1 Yes 2 No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end pleca, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the besis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, dete end place, and due to the cause(s) end manner stated.

29c. License number

Examiner physician end the buriel-transit The law requires that the deeth certificate be executed O. Box 68760. signed by the e been si il director, page 2 s Hospital or Attending Physician: 24 hours efter death. Funeral Director: After this certifice etely filled in by the funeral director. To the Hospital or within 24 hours aft To the Funeral DI completely filled in

Examiner Physician/Medical þ Completed Be Certification: To edical

Physician

/Medical

Examiner

Funeral

Director

r 28a-f show inchilled at

r than "natural", or items 23s or the Medical Examiner must be r

200

should be filed within

Pages 1 and 2 Department of Health a Important: If them 27 is any injury or other tra

Baltimore,

and Mental merked

#

Physician /Medical Director

Funeral

p

Completed

Division of Vital Records, P.

State Registrar

31. Date filed (Month, Dey, Year) JAN 2 8 ZUU0

rasha

29b. Signature and title of cartifier

2 Accident

3 Sulcide

29a, Certifier

4 Homicide

Morrod

Investigation

6 Could not be determined

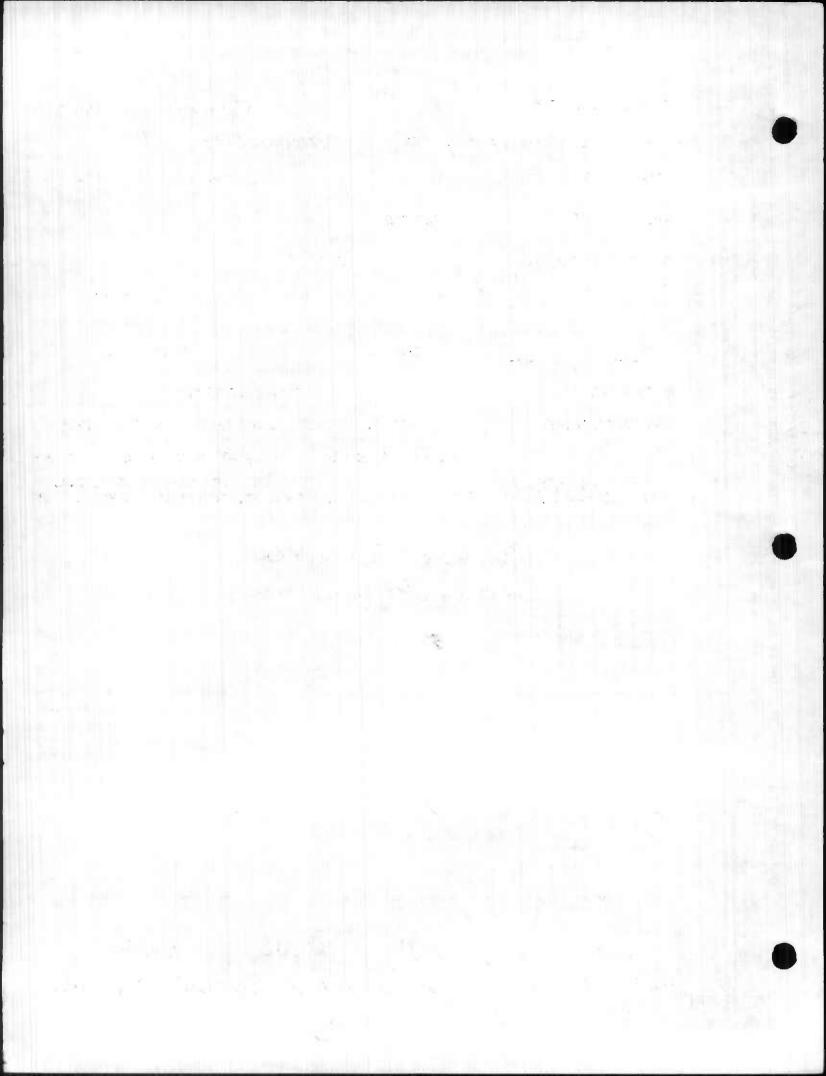
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrer's Signeture

28e. Pleca of Injury - At home, farm, street, fectory, offica building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Dete signed (Month, Day, Yeer)

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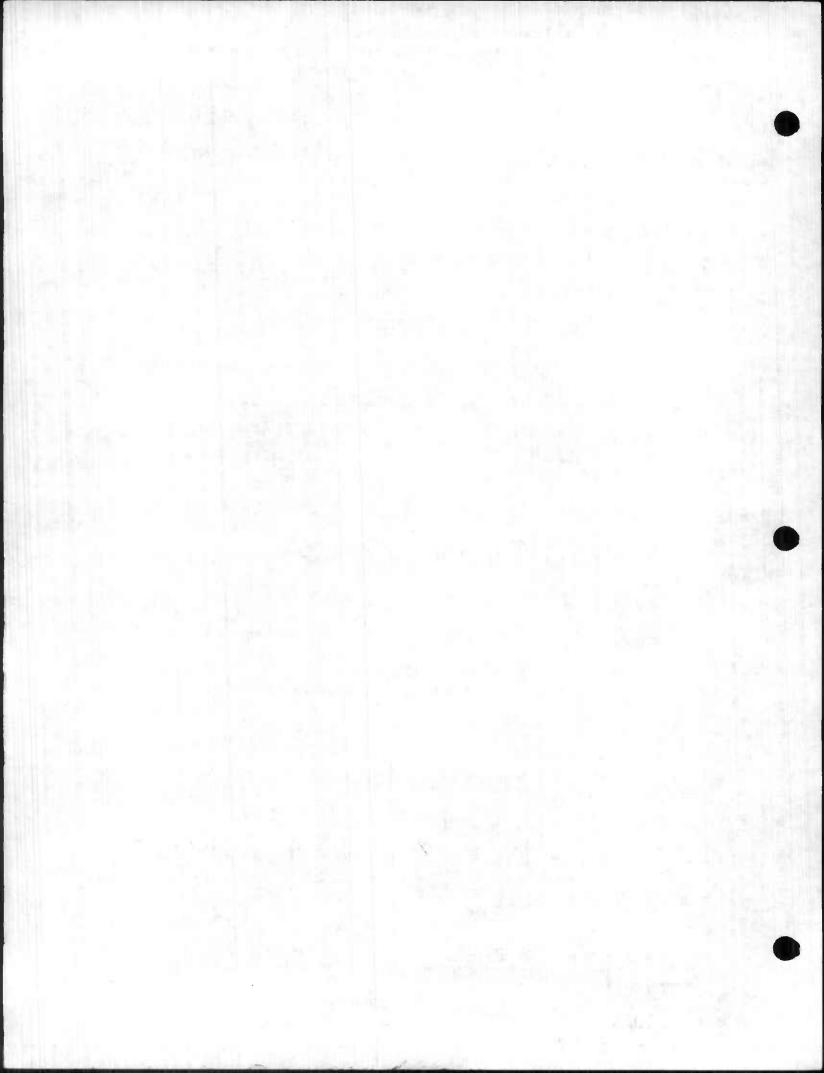
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| | DAMEON WHEELER | | | State of M | arylan | | ment of I icate of | dealth and Death | Mental Hy | rgiene () | 0 0 | 2126 |
| П | Physicia | n | 1. Decedent's Nama (First, Middle, Last) | 1 | | / 1 | 7.0 | | 2. Data of Do Month | eath Day | Year | 3. Time of Death |
| Q. | /Medic | al | DAMEON | LEE | - (| NHEE | -LE-R | | JANUAI | | | 8:11P.M. |
| d | Examin | er | 4a Facility Name (If not institution, giva s | | | | | 4b. City, Town, or | | th 4c. County | of Death | |
| _ | . 5 | | JOHNS HOPKINS HOSP 5. Social Security Number 6. Sax | | a (In vrs. | last birthday) If | Under 1 Yaar | BALTIMO | | rth / | 9. Birthola | ce (State or Foreign |
| 1 | Funeral Director | | | M 2□ F | 2 | O Yrs. Me | onths Days | Hours Min. | 8. Date of Bi | ay. Year) 21.1979 | | ce (State or Foreign y) RV LAND |
| | | | Usual Residence of Decedent | | | | | | | 17.7.7 | | 1 |
| | hours after death with the Maryland tural", or flems 23s or 28s-f show at Exercine must be notified at | _ | 10s. State 10b. County | , | 10c. City | y, Town or Location | on | | 7 | , | 100 | d. Inside City Limits 1☑ Yes 2☐ No |
| | the M | Director | MARYLAND N/ | A | | 20 | ALT/ Of. Zip Code | HORE | CITI | 10g. Citizen of V | What Country | -/- |
| | with with | ត់ | 3551 EMLEN | 1 0.15 | 4/115 | | 01. 21p C000 | 2121 | 2 | | 5A. | y · |
| | Jeath Tre 23 | Funeral | | 2. Was Decedent | | | Decedent of I | Hispanic Origin? (S an, Mexicen, Puer | specify Yas or N | | e - Amaricer | |
| 0 | or hems | | 1 Nevar Married 2 Married | Armed Forces? 1 ☐ Yas 2 ☑ | No | | s, specify Cub Yes 2⊠No | | to Rican, etc.) | | k, White, et | c. |
| 5-0020 | raf. | þ | 3 ☐ Widowed 4 ☐ Divorced | If Yes, Give Year or Dates: | | 10 | Tes ZETNO | Specify: | | Specify | BLA | TCK |
| 5-(| 72 h netu | Completed | 15. Decedent's Educ (Specify only highest grade | cation completed) | | 16a. Decedent' (Give kind | s Usual Occup of work done | pation during most of word) | rking | 16b. Kind of Bu | isiness/Indu | istry |
| 2121 | within ene. | d L | Elementery/Secondery (0-12) | College (1-4or | 5+) | | UDEA | 1 - | | HIGH | 150 | 4221 |
| | filed with Hygiene. offher the | Ö | 17. Fathar's Nama (First, Middle, Last) | | | 0/0 | AUER | | ma (First, Middle | , Maiden Sumam | | HOOL |
| aryjand | lental ked c | To Be | RICHARD L | FE | WH | HEELER | 2 | TER | RIE | GA | TINE | 5 |
| any | d 2 shouth and N Is man | - | 19a. Informant's Name/Relationship (Ty) | oe, Print) | | | _ | and Number or Ri | | | | |
| Z | and 2 palith 2 127 ls | | RICHARD & TERRIE | HEELER P | 4RENTS | 3551 | EML | EY AVE | NUEL | BALTO, A | 10.2 | 1213 |
| ore | If then or oth | | 20a. Method of Disposition 12 Burial 2 Cremation 3 R | emoval from State | 20b. P | lace of Dispositio ematery, cremato | n (Name of ry or other pla | cel | Date / | 20c. Location - | City or Tow | m, State |
| Baitimore | Pa men | | 4 ☐ Donation 5 ☐ Other (Specify) | | Vo | SHELL | CEI | NETERY | 02-01-00 | BALTI | MORE | MD. |
| Bai | emit. Separti mporti ny inj nce. | | 21. Signature of Fundral Service License | 2 | 1 | 22. Na | sepp | ess of Facility B | ROWN | JR. FUN | ERA | LHOME |
| _ | 00344 | | · (m) | 10n | ن | 21 | 40 N. | FULTOI | JAVE. | BALTO | , MO. | 21217 |
| | | | 23a. Part1. Enter the disease, or complications, or heart failure. List only on | e ceuse on each li | the death | n. Do not enter th | e mode of dyi | ng, such as cerdie | c or respiretory | Arrest, | | Approximate interval Between Onset and Death |
| | Physician /Medical | | Immediate Cause (Final | a | 1 - | 11 1 | + | 1 | | | | |
| | Examiner | | disaase or condition resulting in death) | Junst | at 1 | r as a consequen | Lo Ch | st | | | 1 | |
| | | Je | | | Due 10 (0 | as a consequen | OB OI). | | | | | |
| | an and rial-transit | Examiner | Sequentially list conditions, if any, leading to immediate | | Due to (o | r as a consequen | ce of): | | | | | |
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| 6876 | eath certificate be attending physici for use as the bu | Physician/Medica | Cause (Disease or injury that initiated events resulting in death) Last | | Dua to (or | r as a consequent | ce of): | | | | | |
| 9 x | death certificate e attending phys ed for use as the | Me | | | | | _ | | | | | Superior |
| Вох | attendation for us | cian | | | | | | | | | 1 | |
| 0 | res that the deligned by the a | ysi | Part II. Other significant conditions con | tributing to death b | ut not resi | ulting In the under | tying ceuse gi | ven in Part I. | | | a □ Probi | the cause of death? |
| Δ, | 5 60 | by P | | | | | | | " | Yes 2□ No | 3 F100 | ibiy 43 officiowii |
| Records, | been sign should be | 8 | | | | | | | 24a. Wa | s an autopsy ormed? | | re autopsy findings ileble prior to |
| 00 | > 10 00 | Completed | | | | | | | pan | onneg | com | pletion of cause eath? |
| 2 | The la | E | | | | | | | 1 | Yes 2 No | 1× | Yes 2 No |
| Vital | ysician: The lav is certificate has director, page 2 | Be | 25. Was case referred to medicat examiner? | | | | | 26. Plece of De | eth (Check only | one) | | |
| of | 40. 200 | 2 | 1 N Yes 2 No | ospital: 1 Inpatio | ent 2 💢 | ER/Outpatient | JU DOA | | | idence 6 Oth | |) |
| E 0 | Ing P Wher t | 0 | 27. Manner of Death 1 ☐ Neturel 5 ☐ Pending | Month, Da | y Year) | 28b. Tima of Injury | 28c. Inju Wo | | 28d. Describe | how Injury occur | red | |
| Sic | death death ttor: | Icat | 2 Accident Investigation 3 Suicide 6 Could not be | 726/6 | | 1/20 | | Yes 27 No | 28t Location | (Street and Numb | er or Rural | Route Number |
| Division | Direct Timb | Certification: | Homicide | building, et | c. (Specif) | steps o | f hour | | City or To | wn, State) / 8 | or blac | IF North |
| | | | 29e. Certifier 1☐ Certifying Phys | Iclan: To the best | of my kno | | | | 1 | cause(s) and ma | nner as sta | Hotel / |
| | P Ho P Fur | edical | (Check only one) 27 Medical Examin | | exeminal | | | | | | | |
| | THE PROPERTY | 7 | 29b. Signature and title of certifier | . , 1, | | | 29c. Licen: | se number | | 29d. Date signe | d (Month, D | ay, Year) |
| | 1111/ | , | Theoder | 4.1/ | 4 | | 0. | C.M.E. | | JANUAR' | Y 27,2 | 2000 |
| | 1111 | 4 | 30. Nama and address of person who co | 4 | leath (terr | | | | | | | 01051 |
| | | 1 | THEODORE MIL | 2 | 0 | | 11 Penn | Street, | Baltim | ore, Mar | yland | 21201 |
| | Stat Registe | ٧ | 31. Date filed (Month, Day, Year) | 32. Registr | ars Signa | ture | pour | | | | | |
| 100 | - | | 111111 2 0 2000 | 7-1 | | # Management | A STATE OF THE PARTY OF THE PAR | | | | | |

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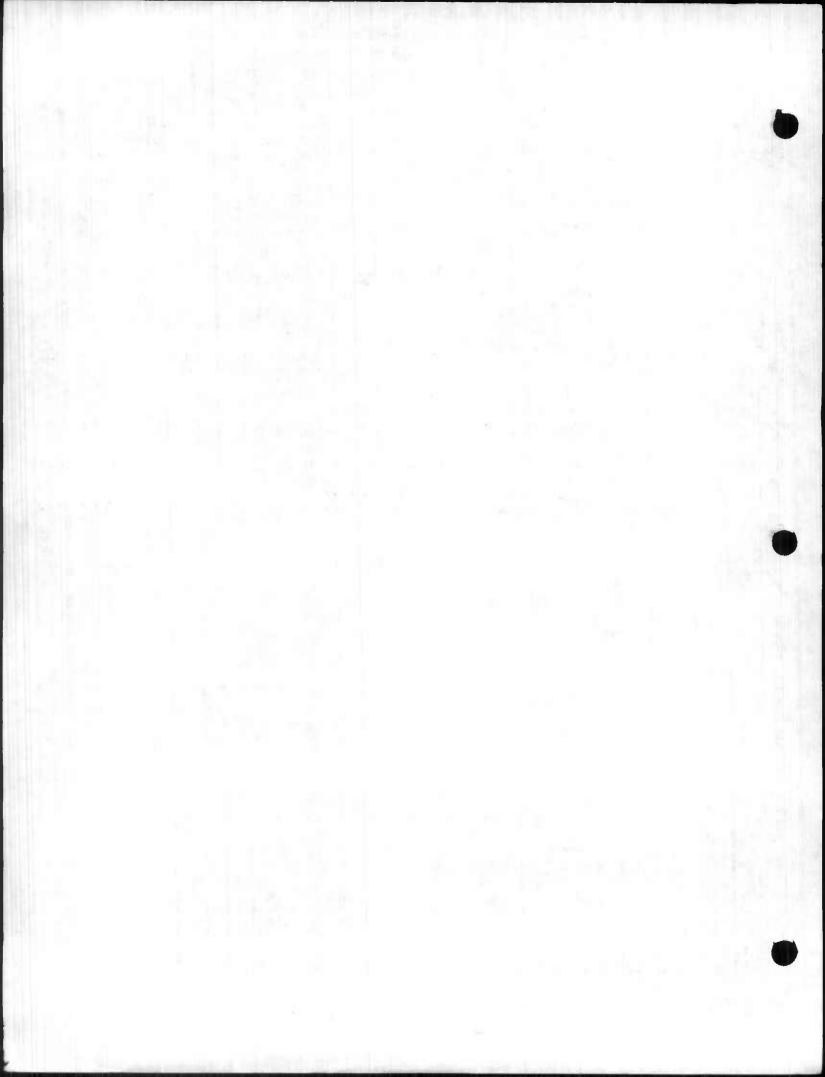


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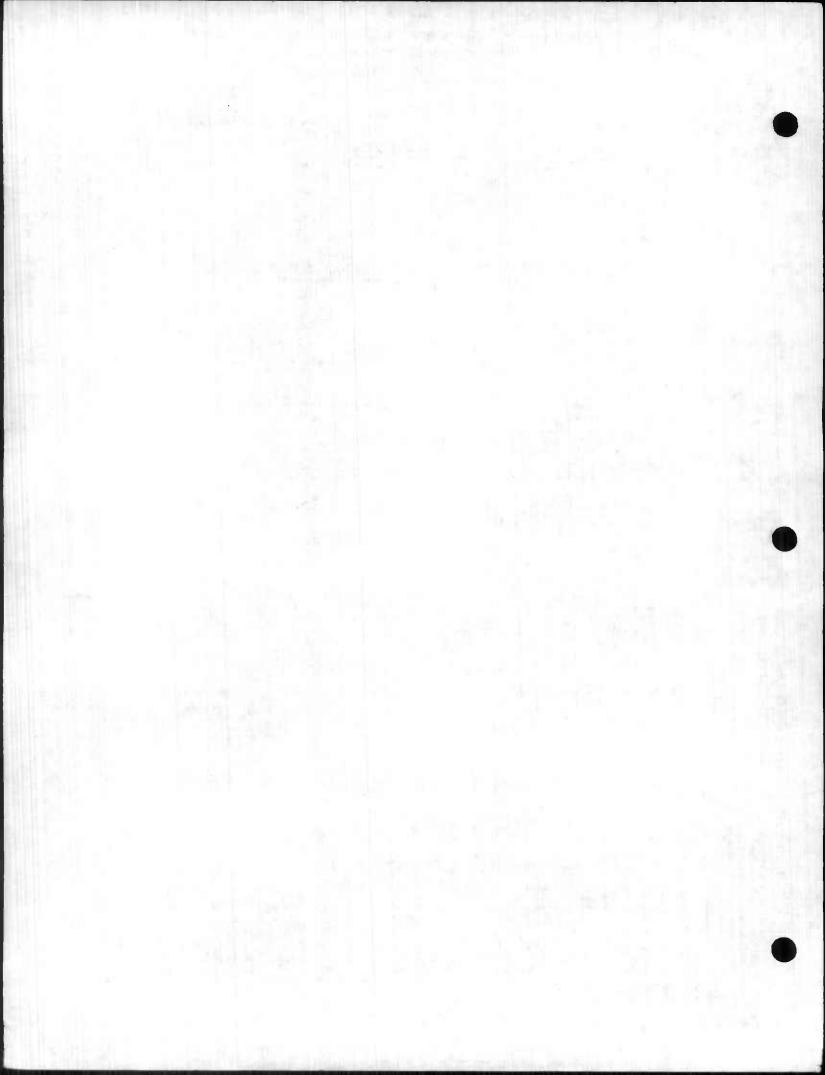
| | | | Certifica | ate of L | Death | | Reg. No. | U las 1 Eu 1 | |
|--|--|---|------------------------------------|---|---------------------------------------|--------------------------------------|---------------------------------------|--|--|
| sician 1 | . Decedent's Name (First, Middle, Last | | | | _ | 2. Dete of De | | 3. Time of Do | |
| | sames cl | IFTON L | DILLIAM | ns | SR. | Month JAN. | 22.21 | 000 3:00 | |
| | a Facility Name (# not institution, giva | street and number) | | 41 | b. City, Town, or | Location of Death | 4c. County o | of Death | |
| 1 | 124 W FRANK | LIN STREET, | APT. #13 | 04 1 | 3ALTIV | MORE | NI | 9 | |
| 5. | . Social Security Number 6. Se | | last birthday) If Und | der 1 Yaar | If Undar 24 Hrs Hours Min. | | h Year) | 9. Birthplece (State or F Country) | |
| 5 | 226-14-5554 | M 20 F 87 | Yrs. | | | AUCUST | 13,1918 | VIRGINIA | |
| - | Jsuel Residence of Decedent 0a. State 10b. County | 100 0 | he Tour as Lagation | | | | | 40d Inside Oile | |
| | | | ty, Town or Location | 0 - | 01 | | | 10d. Inside City 1 X Yes 2 | |
| - | ARYLAND N/A Oe. Street and Number | | ALTIMO | Zip Code | CITY | | | | |
| | hat Country? | | | | | | | | |
| / | A. | | | | | | | | |
| 1 | | 12. Was Decedent Ever in L Armed Forces? | J,S. 13. Wes De If Yas, s | cedent of His pecify Cuber | spanic Origin? (S n, Mexican, Puer | Specify Yes or No to Rican, etc.) | | - Amarican Indian, , Whita, etc. | |
| | 1 Never Merried 2 Merried | 1 ☐ Yaa 2 1 ♥ No If Yes, Give | 1 ☐ Yes | Yea 2 2No Specify: | | | Specify: Q | | |
| | 3 Widowed 4 Divorced | Year or Detes: | | , | | | 10) 10: 1 (0) | Sarah | |
| | 15. Decedent's Edu (Specify only highest grad | | 16a. Decedent's U (Give kind of | work done d | uning most of wo | rking | 16b. Kind of Bus | ineas/industry | |
| 7 | Elementary/Secondary (0-12) | College (1-4or 5+) | | ille. DO NOT use retired) 23T CLASS PAINT | | me dono | | DW'S POINT | |
| | 7. Father's Name (First, Middle, Last) | | FIRST CL | 1422 | | me (First, Middle, | | | |
| | | WILL | sms | | | | | WTON | |
| - | LEONARD | | 19b. Mailing Addre | | CORIN | _ | | | |
| | 19e, Informent's Name/Reletionship (T) | | | | | | | | |
| | RONALD WILLI Oa. Method of Disposition | | Plece of Disposition (/ | | SIHHV | Dete Dete | | RE, MD 8/8 City or Town, State | |
| - | 1 ☐ Burial 2 ☐ Cremation 3 ☐ F | Removal from Stete | cemetary, crematory of | or othar place | , | | | | |
| | 4 Donetion 5 Other (Specify) | n | | | | 01-28-00 | BACTIMO | DRE, MARYL | |
| 2 | 21. Signeture of Funeral Service Licens | 90 | | end Addres | | 110 | ENVERO | AL HOME | |
| | Lutoch | Nalle | | | | | | REMD 218 | |
| 2 | 23a. Part1. Enter the disease, or compl shock, or heart failure. List only or | ications thet caused the dea | th. Do not enter the m | node of dying | , such as cardie | c or respiretory e | rest, | Approximate Intervel Between | |
| | shoot, or heart tailers. Else only or | THE CALCUSC CAT GOOT MILE. | | | | | | Onset end De | |
| | mmediete Cause (Final disease or condition | Reso | INNIT ALI | 15515 | | | | minuted | |
| r | resulting in death) | | or es e consequence | | | | | | |
| | | En | nhysema | | | | | years | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | | | | | | | | | |
| C | | | | | | | | | |
| ti | Cause (Disease or injury hat initieted events resulting in death) Last | Due to (c | or es e consequenca o | of): | | | 1 | | |
| | ooding in document case | | | | | | | | |
| | | d | | | | | | | |
| P | ert II. Other significant conditions con | 23b. Did tobacco use contribute to the cause | | | | | | | |
| | | | | 10 | 3⊠Probably 4□U | | | | |
| - | | | | | | | | (| |
| | | | | | | 24a. Was | an autopsy | 24b. Were autopsy fin- aveilable prior to | |
| _ | | | | | | perio | erneu r | completion of cau | |
| | | | | | | 10 | Yes 2 QNo | 1 🖫 Yes 2 🗆 N | |
| 2 | 25. Was case referred to medicat | | | | 00 Disease 4 Dis | | | 17103 2010 | |
| - | examiner? | fospitel: | 1000 | DOA Othe | Ar. | eth (Check only o | | - 1014.1 | |
| 2 | 1 ☐ Yes 2 ☑No | 28a. Dete of Injury | ER/Outpetient 3□ 28b. Time of | DUA | 4 LI Nursing | Home 5 Resi | denca 6 Li Othe how injury occurre | | |
| | 1 Pending 5 □ Pending | (Month, Day Year) | Injury M | 28c. Injury Work | ? Yes 2 □ No | | , , , | | |
| | 3 ☐ Suicide 6 ☐ Could not be | 28e Plece of Injury - At h | | | | 28f. Location (| Street and Numbe | er or Rural Route Numbe | |
| | 4 ☐ Homicide determined | 28e. Plece of Injury - At h building, etc. (Speci | (h) | iory, omou | | City or To | vn, State) | | |
| _ | 9a. Certifier 1 T Certifying Phys | sisten. To the best of much | autodao doeth a | ad at the ti- | a data and street | a and due to the | course/s) and m | anor as etated | |
| - | | sician: To the best of my kno ner: On the basis of examine | | | | | | | |
| 0 | | and menner ateted. | | 29c. License | number | | 20d Data signed | (Month, Day, Year) | |
| ć | 9b. Signature and title of certifier | | | | 2/13 | | -t | 2.7 - 00 | |
| | 1(1/5) | 8 | | . N. 2 | | | 7 4 | 27 -00 | |
| 3 | 0. Name and address of person who co | | m 23a) (Type, Print) | 014- | B-11 | himore 1 | N) 717 | 4)7 | |
| L | R. SABUNDAVO | 301 | St raul | 1. MC | (, , , ,) | 1,10,0 | | | |
| 3 | 1. Date filed (Month, Day, Year) | 32. Registrer's Sign | eture / | 1 | , | | | | |
| | JAN 2 8 21 | Mener | 27 | Man. | Kal | | | | |

DHMH 16 Rev 6/95

MAL : ARAI



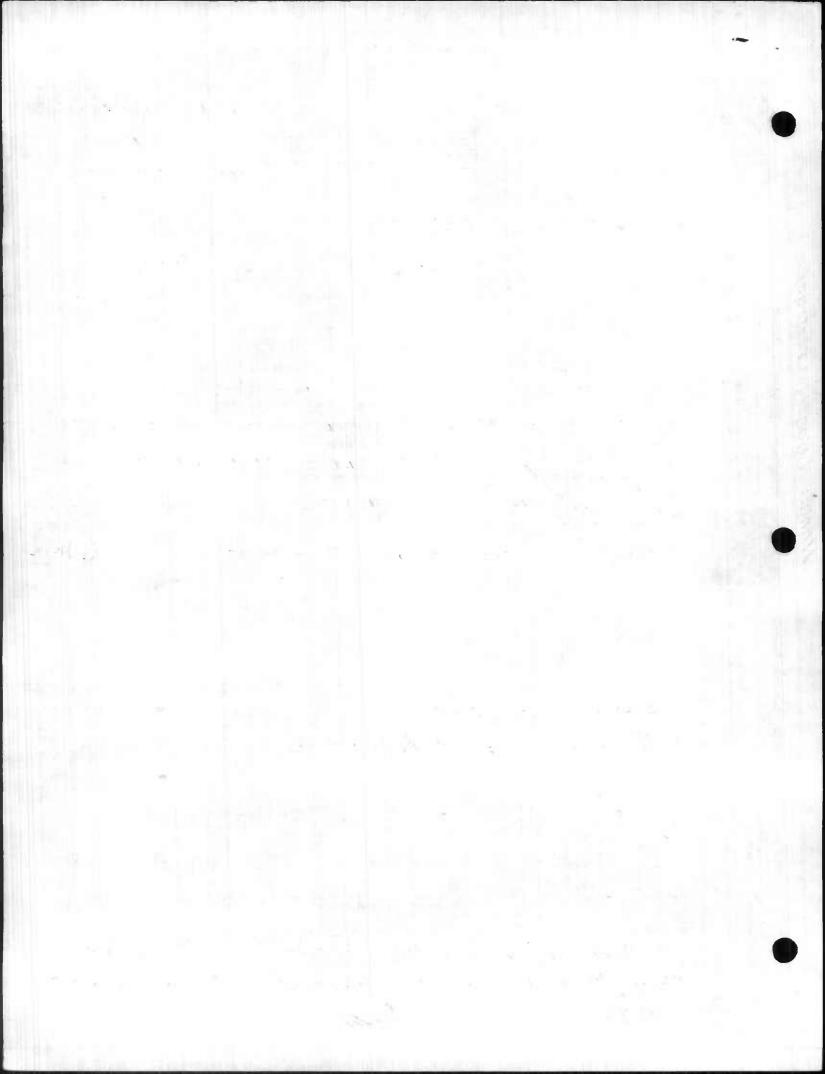
DHMH 16 Ray 6/95



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician Gertrude J. Woolf JANUARY 6:35PM 25,2000 /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** GREATER BALTIMORE MEDICAL CENTER TOWSON BALTIMORE If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. lest birthday) 9. Birthplaca (State or Foreign Country) 8. Dafe of Birth (Month, Dey, Year) **Funeral** Months Days Hours 220-03-5626 **Director** April 11, 1912 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28s-f show 1 ☐ Yes 2 ☐ No Directo Maryland Baltimore Lutherville 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ò Items 23a 804 Roundtop Court Apt. 2D U.S.A. 21093 Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Merried Baltimore, Maryland 21215-0020 "natural", or 1 ☐ Yes 2 ☐No Specify: Specify: by 3 Widowed 4 □ Divorced White Completed permit. Pages 1 and 2 should be filed within 72. Department of Health and Mentel Hygiene. Important: If them 27 te marked other than "naturable avairable pages. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Home Maker Own Home 17. Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Charles Jahelka Pansy Pearl Baker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Jo Anna Eichelberger/Dtr. 8507 Dempster Court Apt. F Baltimore, Md. 21234 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) Date 20c. Location - City or Town, Stata 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Druid Ridge Cemetery 1/29/2000 Pikesville, Maryland 21. Signature of Police & Service License 22. Neme end Address of Facility 1050 York Road Ruck Towson Funeral Home, Inc. Towson, Md. 21204 23a. Part1. Enter the discourshock, or heart facure. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, usually one cause on each line. Approximate Interval Between Onset and Death **Physician** PNEUNUMIA HOURS /Medical Immediate Cause (Final IKATION disease or condition resulting In death) Examine Due to (or as e consequenca of) Examiner sician end burial-transit be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lesf Due to (or as a consequence of): Box 68760. Physician/Medical the Due to (or as e consequence of) Part II. Other algnificant conditions contributing to death buf not resulting in the underlying cause given in Part I. P.O. 23b. Did tobacco usa contribute to the cause of death? FIBRILLATION 1 Yes 2 No 3 Probably 4 Unknown Records, ð DIABETES, INSULIN REQUIRING 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was en autopsy The 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital Attending Physician: funeral director, Be 25. Was case referred to medical axaminer? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 TYes 2 T€No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A Investigation 2 Accident 6 Could nof be determined 3 Suicide 281. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Placa of Injury - At home, farm, sfreef, factory, office building, etc. (Specify) à 4 Homicide 6 the Hospital edicai le Certifying Phyalcian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signefure and title of certifier 29d. Date signed (Month, Day, Year) alegan 100 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NATHAN ROSENBLUM MD 7600 OSLER DRIVE TOUSON MD 21204 31. Dete filed (Month, Dey, Year) 32. Registrer's Signature State JAN 28 2000 Registrar

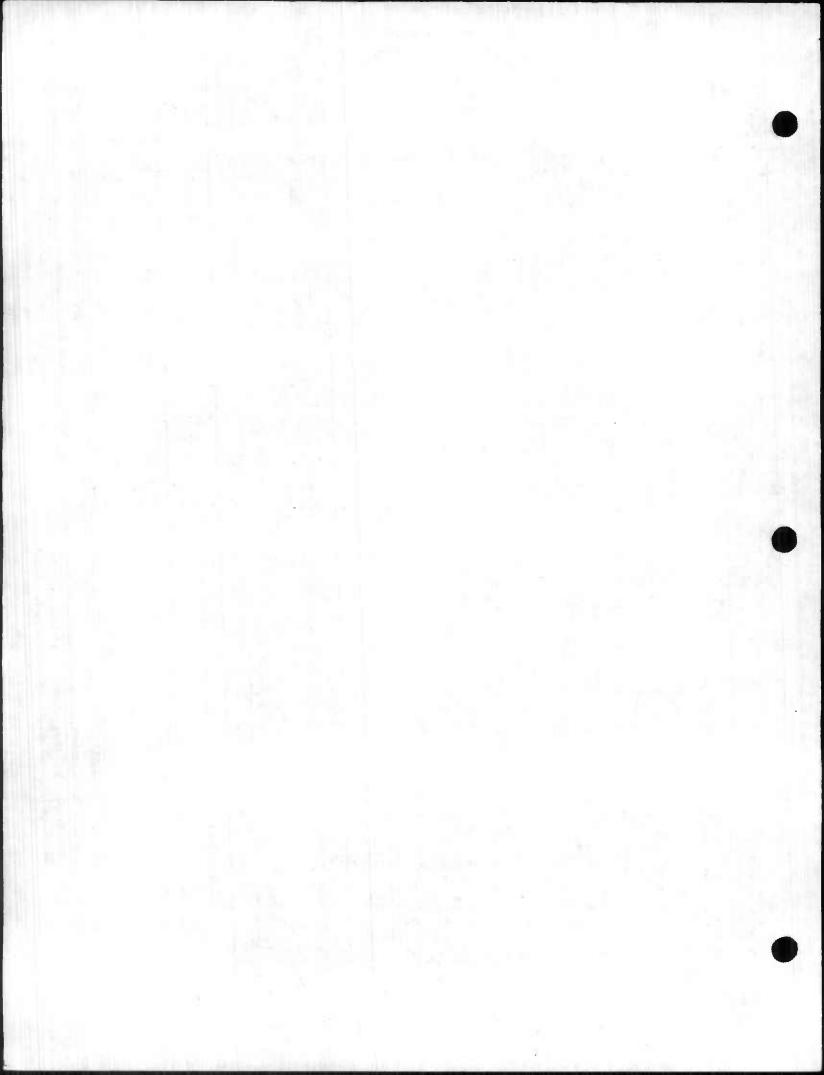
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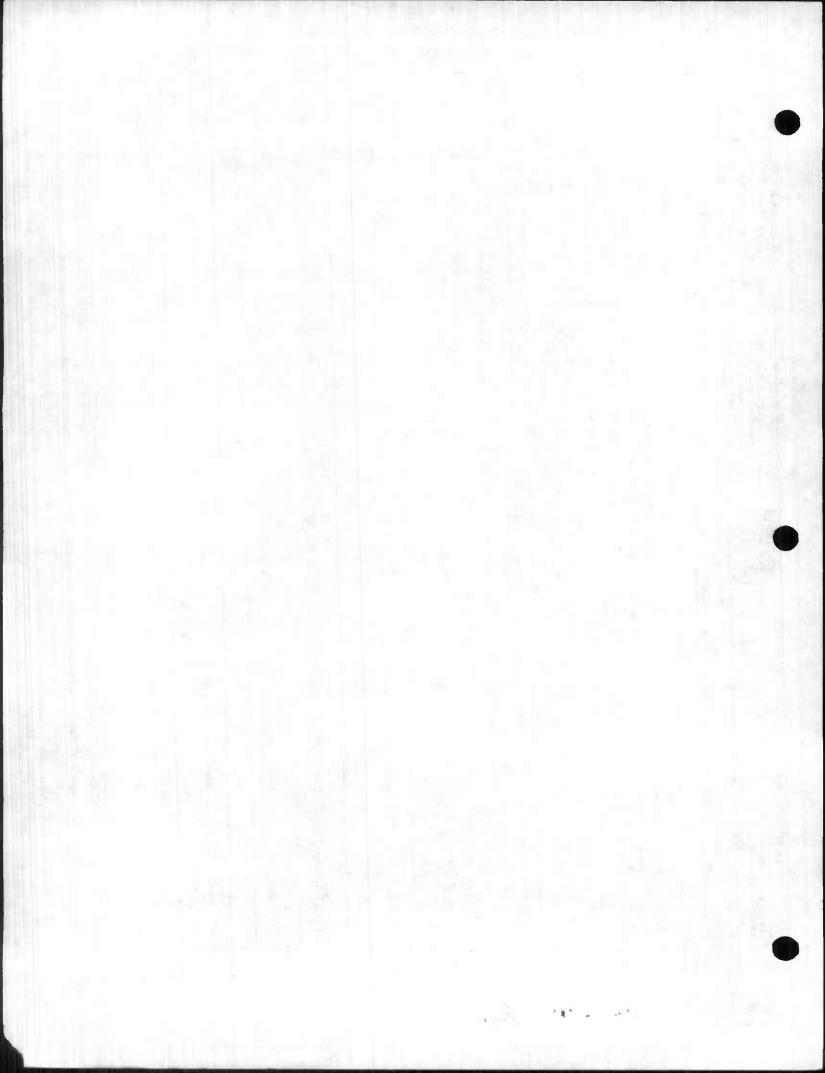
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 0 2 1 3 0

| | | | | Certificate of | Death | Re | g. No. | | | |
|--|---|--|--|---|-----------------------------------|---------------------------|-------------------------------|---|--------------------------------------|--|
| | 1. Decedent's Nama (First, Middle, La | st) | | | | 2. Deta of Death Month | | Yeer | 3. Tima of Death | |
| Physician /Medical | | Hazel We | 11 W: | ilson | | January | | | 4:35 PM | |
| Examiner | 4a Facility Name (If not Institution, giv | e street and number) | | | 4b. City, Town, or | Location of Death | 4c. County of | Death | | |
| | Crofton Nursing | Center | | | Crofton | n | Anne | Arun | del | |
| Funeral Director | 5. Social Security Number 6. S 216-34-9010 | 7. Age (In 81 | yrs. last bir | thdey) If Under 1 Yas Months Day | | | | 9. Birthpla Country Virg: | ce (State or Foraig y) inia | |
| 2 . | Usual Rasidence of Decedent 10a. Stete 10b. County | 100 | City Town | n or Location | | | | 100 | d, tnside City Limit | |
| style show data | | | . Ony, Town | | | | | 100 | 1 ☐ Yas 2 ☑ N | |
| or 28a-fre be notified Director | 7 | arroll | | Hamp 10f. Zip Code | stead | 10 | a Citizen of 18/h | ot Countr | | |
| | 10e. Street and Number | | | Tor. Zip Code | 0.7 | | 10g. Citizen of Whet Country? | | | |
| ount b | 4395 Down Hill | | | Landa December of | | | Inited S | | | |
| ar, or items 23a Examiner must by Funeral | 11. Marital Status 1 Never Married 2 Married 343 Wildowed 4 Divorced | 12. Was Decedent Evar Armed Forcas? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Detas: | rmed Forces? It Yas, specify Cuban, Mexican, P Yes 2⊡No Yes, Give 1 □ Yes 2⊡No Specify: | | | rto Rican, etc.) | | 14. Race - American Indian, Black, Whita, etc. Specify: White | | |
| ted bet | 15. Decedent's Ed | ducation | 16a. | Decedent's Usuai Occ | upation | and the second | 6b. Kind of Bus | iness/Indu | stry | |
| ypiene. Ner than "neturn It, the Medical Completed | (Specify only highest gra Elementary/Secondary (0-12) 7 Years | Coilege (1-4or 5+) | | (Give kind of work don life. DO NOT use retin | e during most of wi red) | orking | Own H | Iome | | |
| d other went, Be C | 17. Father's Name (First, Middle, Last, |) | | | 18. Mother's Name (First, Middle, | | | | | |
| Menta irked stic ev | Joseph Shifflett | Shifflet | + | | | | | | | |
| M DE P | 19a. Intormant's Name/Relationship (| Rural Route Number, | | State, Zip C | Code) | | | | | |
| 27 is 27 is 17 to | Ronald L. Wilson | *** | | 988 Fox Cha | | | | | | |
| Ham Share | 20a. Method of Disposition | 20 | b. Plece of | Disposition (Name of | | Dete 2 | Oc. Location - C | ity or Tow | n, State | |
| 10 H III | H Burial 2 Cremation 3 | | | y, cremetory or other p ns of Faith | | 1/27/00 | Dogodo | lo M | la secol a m d | |
| offernit of the control of the contr | 4 □ Donation 5 □ Other (Specification 21, Signature of Funaral Service Licer | 1/2//00 | Roseda. | ie, M | laryland | | | | | |
| Depa Impo | Johnny Zx | 9. Jac | | | Funeral | Home of I | | | | |
| | 23a. Part 1. Enter the disease, or com | plications that ceused the | death. Do r | not enter the mode of d | ring, such es cerdi | ac or respiratory arre | st, | | Approximata nterval Between | |
| Physician | shock, or heart tailure. List only one ceuse on each line. | | | | | | | | | |
| Tiysician | Immediate Cause (Final | | | 21.001 | | | | | | |
| xaminer | disease or condition resulting in death) | a | PIA | allon 1 | neun | elvery | | 0 | week | |
| ة ا | I I I I I I I I I I I I I I I I I I I | Due | to (or as a | consequence of): | 11.1 | 00 010 | .1 | | C VO | |
| min nsit | | b. Cnd | | Stage | 17131 | ecmens | ause | re | J Tear | |
| physician and s the burial-transit edical Examir | Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Due to (or as a consequence of): | | | | | | | | | |
| a pri | Cause (Disease or injury | c | | | | | | | | |
| as the bur | resulting In death) Last | Due | to (or as e o | consequence of): | | | | | | |
| 04 | | | | | | | | | | |
| igned by the attending be detached for use a by Physician/M | | | | | | | | 1 | | |
| y the ached | Part II. Other significant conditions of | ontributing to death but no | t resulting in | the underlying ceuse | given in Part I. | 23b. Dtd tol | pacco use cont | tribute to 1 | the cause of deat | |
| ed by detac | | | | | | 1 □ Ye | 8 2 No | 3 Probe | ably 4 Unkno | |
| b b | | | - 7 | | | - | | | | |
| page 2 should be Completed by | - 2.7 | | | | | 24a. Was an parform | autopsy red? | avai | e autopsy finding: lable prior to | |
| | | | | | | | | of de | pietion of causa eath? | |
| age age | | | | | | 1□ Ya | s 2 No | 10 | Yes 22 No | |
| certificate has b lirector, page 2 s | 25. Was cese referred to medical | | | | 26 Place of D | eath (Check only one | | | | |
| rector irector | examiner? | Hospital: | • C ED/O | | | Home 5 Reside | | - (Canaita) | | |
| this certific ral director, To Be | 27. Manner of Death | 28a. Date of Injury | 2 ER/Ou | | | 28d. Describe ho | | | | |
| octor: After by the funer ification: | 1 ⊠Natural 5 □ Pending | (Month, Dey Yea | | njury W | ork? □ Yes 2 □ No | | | | | |
| after death. Director: A I in by the fu | 3 Suicide 6 □ Could not b | e on piece Aleine | At home to | | | 28t. Location (Str | net and Numba | r or Burel | Poute Number | |
| Her in by | 4 ☐ Homicide determined | building, etc. (S) | ecify) | rm, street, tactory, offic | 9 | City or Town | Stete) | or norar | riodia ivambal, | |
| ral Dir fled in | | | | | | | | | | |
| within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director, Medical Certification: To Be (| | nysician: To the best of my niner: On the basis of exar and manner stated. | | | | | | | | |
| within 24 hours To the Funeral completely filled Medical Co | 29b. Signature and title of certifier | | | 29c. Lice | nse number | . 29 | d. Date signed | (Month, D | lay, Year) | |
| 3 ⊢ ŏ | W. 0 | 111 |) | D | 2202 | 8 | 1 24 | .00 | 7 | |
| \ | 1 me | / houl | An | 7 | | | 1 - 2 - | | | |
| () | 30. Name and eddress of person who | completed ceuse of daeth | (Item 23a) | (Type, Print) | 0 .1 | · | 4 . 1 | 2111 | | |
| 1 | 30. Name and eddress of person who completed ceuse of deeth (Item 23a) (Type, Print) Out S Rhodes MD 1667 Crifton Center Crifton 21. Data bild (Month Day York) | | | | | | | 4111 | 4 | |
| State | 31. Data tiled (Month, Day, Year) | 32. Registrar's S | Signature | , 1 , | , | | | | 1 | |
| Registrar | JAN 2. 8 200 | 1 Jenson | V | I spark | 21 | | | | | |

ORIGINAL



| Recommend Reco | KEVIN WILI | 1/28/2000 reb Item: 28b per MEO. Item: 20b per F. H. G-779 1. Decedent's Name (First, Middle, Last) 1/28/2000 reb Certificate of Death | 2. Date of Dea | Reg. No. | 2. Time of Death | | | | | | | |
|--|---|---|---------------------------------------|---|-------------------------------------|--|--|--|--|--|--|--|
| ## Fastly Number of Protection FOUNDATION FOUNDATION | | | Month | Day Ye | | | | | | | | |
| Social Security Number Secur | 7 | | | | Death | | | | | | | |
| The Siere and humber 100. Courty BALTIMORE 100. College of White Columnity 100. College of White Columnity 100. College of | Director | 212-96-9157 18 M 2 F 19 Yrs. Months Days Hours Min | . (Month, Day | of Birth h, Day, Year) 9. Birthplace (State Country) | | | | | | | | |
| Company Comp | | | | | 10d. Inside City Limits | | | | | | | |
| Company Comp | the Mar offilled octor | DIE TITOLE | | 1 No 2 No | | | | | | | | |
| 12 Ves X/No. Specific Speci | Se or 2 | 2054 | | t Country? | | | | | | | | |
| 20a. Method of Disposition State 20c method of Disposition State 20c method 3 Remove from State 4 Dorston 5 Come (Speech) MT. ZION CEMETERY 25 MB ALTIMORE, MD MR. CHI FUNERAL HOME WEST, INC. 4 Dorston 5 Come (Speech) MT. ZION CEMETERY 4 Dorston 5 Come (Speech) 4 Dorston 5 Come (Speech) MT. ZION CEMETERY 4 Dorst | | 11. Marttal Status 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☑ Never Married 2 ☐ Married If Yes, Give 13. Was Decedent of Hispanic Origin? (5 If Yes, specify Cuban, Mexican, Puer If Yes, Give 1 ☐ Yes 3€ No Specify: | Specify Yes or No- to Rican, etc.) | 14. Rece - A Black, V | White, etc. | | | | | | | |
| 20. Method of Disposition Size 20 chemical 3 chemic | 72 ho natural disal | (Specify only highest grade completed) (Give kind of work done during most of wo | orking | 16b. Kind of Busine | ess/Industry | | | | | | | |
| 20. Method of Disposition Substantial Su | t within lene. The Me | Elementary/Secondery (0-12) College (1-4or 5+) | | | | | | | | | | |
| 20. Method of Disposition Substantial Su | be filled d other swent, | 17. Father's Name (First, Middle, Last) 18. Mother's Na | me (First, Middle, | | | | | | | | | |
| 20. Method of Disposition Size 20 chemical 3 chemic | d Men marks marks To | | | | te. Zin Codel | | | | | | | |
| 23a. Pela: Finer Misseas or completations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest. Physician Miscellical Examiner | 20 m cs 20 | MURDEGA ADMORDONG MORNEY COST | | | | | | | | | | |
| Physician (Medical Examiner) 22a. Palt: Enter the disease or completations that usuade the death. Do not enter the mode of dying, such as cardiac or respiratory errest. 22a. Palt: Enter the disease or completations that usuade the death. Do not enter the mode of dying, such as cardiac or respiratory errest. 22b. Palt: Enter the disease or completations that usuade the death. Do not enter the mode of dying, such as cardiac or respiratory errest. 22c. Palt: Enter the disease or conditions. 22c. Palting the death of the death of the death of the death. Do not enter the mode of dying, such as cardiac or respiratory errest. 22c. Palting the death of the death of the death. Do not enter the mode of dying, such as cardiac or respiratory errest. 22c. Palting the death of the death. Do not enter the mode of dying, such as cardiac or respiratory errest. 22c. Palting the death of the death. Do not enter the mode of dying, such as cardiac or respiratory errest. 22c. Palting the death. Do not enter the mode of dying, such as cardiac or respiratory errest. 22c. Palting the death. Do not enter the mode of dying, such as cardiac or respiratory errest. 22c. Palting the death. Do not enter the mode of dying, such as cardiac or respiratory errest. 22c. Palting the death. Do not enter the mode of dying, such as cardiac or respiratory errest. 22c. Palting the death. Do not enter the mode of dying, such as cardiac or respiratory errest. 22c. Palting the death. Do not enter the mode of dying, such as cardiac or respiratory errest. 22c. Palting the mode of dying, such as cardiac or respiratory errest. 22c. Palting the mode of dying, such as cardiac or respiratory errest. 22c. Palting the mode of dying, such as cardiac or respiratory errest. 22c. Palting the mode of dying, such as cardiac or respiratory errest. 22c. Palting the mode of dying, such as cardiac or respiratory errest. 22c. Palting the mode of dying, such as cardiac or respiratory errest. 22c. Palting the mode of dying, such as cardiac or respiratory er | Pages 1 a nent of His ant: If Nam ary or other | 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from State | | | | | | | | | | |
| Physician (Acdical Examiner) Physic | permit. Depart Imports any inj | 1 July 12 Starry 4300 WABASH AVE. BALTO., MD 212 | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Un | Medical Examiner Harnsit Ample Carted | Due to (or as a consequence of): Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated eyents | CHES | 57 | SECONSS | | | | | | | |
| 1 Yes 2 No 3 Probably 4 Un | CH CH III | d | | | 1 | | | | | | | |
| September 2016 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 | that the sed by the detache | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | buts to the causs of death? ☐ Probably 4 ☐ Unknow | | | | | | | | |
| 25. Was case referred to medical examiner? | w requisite piete | | | | completion of ceuse | | | | | | | |
| 30. Name and suffrest of tensor who completed cause of death (Item 23a) (Type, Print) ACEK 111 Penn Street, Baltimore, Maryland 21201 State 31. Date filed (Month, Day, Year) 32. Registrar's Signature | ificate or, pag | 25. Was case referred to medical 26. Place of De | / | | 1 Xes 2 No | | | | | | | |
| 30. Name and authors of the street of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature | aysicle bis cert direct | examiner? Hospital: Other | | | Specify) SCENE | | | | | | | |
| 30. Name and suffrest of tenion who completed cause of death (Item 23a) (Type, Print) ACEK 111 Penn Street, Baltimore, Maryland 21201 State 31. Date filed (Month, Day, Year) 32. Registrar's Signature | Ing Pl | 1 1 Vas 2 VNo | 28d. Describe h | now Injury occurred | + | | | | | | | |
| 30. Name and suffrest of tenion who completed cause of death (Item 23a) (Type, Print) ACEK 111 Penn Street, Baltimore, Maryland 21201 State 31. Date filed (Month, Day, Year) 32. Registrar's Signature | or Attend after death Director: d in by the | 2 Accident investigation 1425 M 1 Yes 2 No + OUA S 10 / S 1 Suicide 3 Suicide 4 Althomicide 28e. Place of Injury - At home, farm, street, fectory, offica 28l. Location (Street and Number or Rural Route City or Town, State) 4 C+ | | | | | | | | | | |
| 30. Name and sufficient of the sum of the su | 24 hours Funera etely fille dical C | (Check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occ | a, end due to the | ceuse(s) and menne date and placa, and | er as stated. I due to the cause(s) | | | | | | | |
| State 31. Date filed (Month, Day, Year) 32. Registrar's Signature | To the vithin To the comple | 29t. Signature and the of certifier 29c. License number O. C. M. E. | | | | | | | | | | |
| | d | SMTALEK 111 Penn Street, Baltimon | re, Maryl | and 21201 | 1 | | | | | | | |
| Registrar JAN 2 8 2000 Discourse Mg | | 1AN 9 0 2000 | | | | | | | | | | |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. AMEND#5 PER F.H. G780 2-22-2000 State of Maryland / Department of Health and Mental Hygiene Certificate of Death Item: 20b per F.H G-779 1/28/2000 reb 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** Williams Martin Patricia 1:02PM JANUARY 21,2000 /Medical 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, give street end number) 4c. County of Death Examiner GREATER BALTIMORE MEDICAL CENTER TOWSON BALTIMORE If Under 1 Year 5. Social Security Number 0698 8. Date of Birth (Month, Day, Year) If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2 KF Months 56 Director 216-40-4698 09 27 TN Usual Residence of Decedent the Manyland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ahow al', or items 23a or 28a-f ahov Examiner must be notified at 1 N Yes 2 No Director Baltimore NA MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21215 U.S.A. 7043 Surrey Drive 2nd Floor 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? Race - American Indian, Black, White, etc. 1 ☐ Yes 2 📉 No If Yes, Give 1 Never Married XXMarried "natural", or 1 ☐ Yes 2X No Specify: Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry pernit. Pages 1 and 2 should be filed within Department of Heelth and Mental Hygiene. Important: If Itam 27 Is marked other than any Injury or other traumatic avant, the Ita Elementary/Secondary (0-12) College (1-4or 5+) Levindale N/H 4yrs Nurse 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be nent of Heelth and Mental Benjamin Martin Cardia Pierce 19b. Mailing Address (Street and Number or Rurat Route Number, City or Town, State, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) 21117 10 Woodstream Ct. Apt 9, Owings Mills, Margaret Austin-Daughter 20e. Method of Disposition

1 Description 2 Cremetion 3 Removel from State 20b. Plece of Disposition (Name of Date 20c. Location - City or Town, State Garrison Forest Vet 1/28/2000 Owings Mills, Md ◆ Dorelion 5 Other (Specify) 21. Signature of Funeral Service License 22. Neme and Address of Fecility March F/H West 4300 Wabash Ave, Baltimore Md 21215 nompsm enter the disease, or complications that caused the cheth. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line, Approximate Intervel Between Onset and Death **Physician** Immediate Cause (Final disease of condition resulting in deeth) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Physician/Medical 23b. Did tobacco use contribute to the cause of death? Pert It. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 3 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) Hospitel: 1 Inpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3 DOA this 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28e. Date of Injury (Month, Dey Year) 28b. Time of 1 Natural 5 Pending 1 Yes 2 No 24 hours after death.

Funeral Director: A investigation 2 Accident 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of tnjury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide

Box 68760 O 0 Records,

Williams,

W

Baltimore, Maryland

Division of Vital or Attending Physician; Hospital

Registrar **DHMH 16 Rev 6/95**

within 2 g g

Medical

29e. Certifier (Check only one)

GBMC 6701 31. Dete filed (Month, Dey, Year)

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

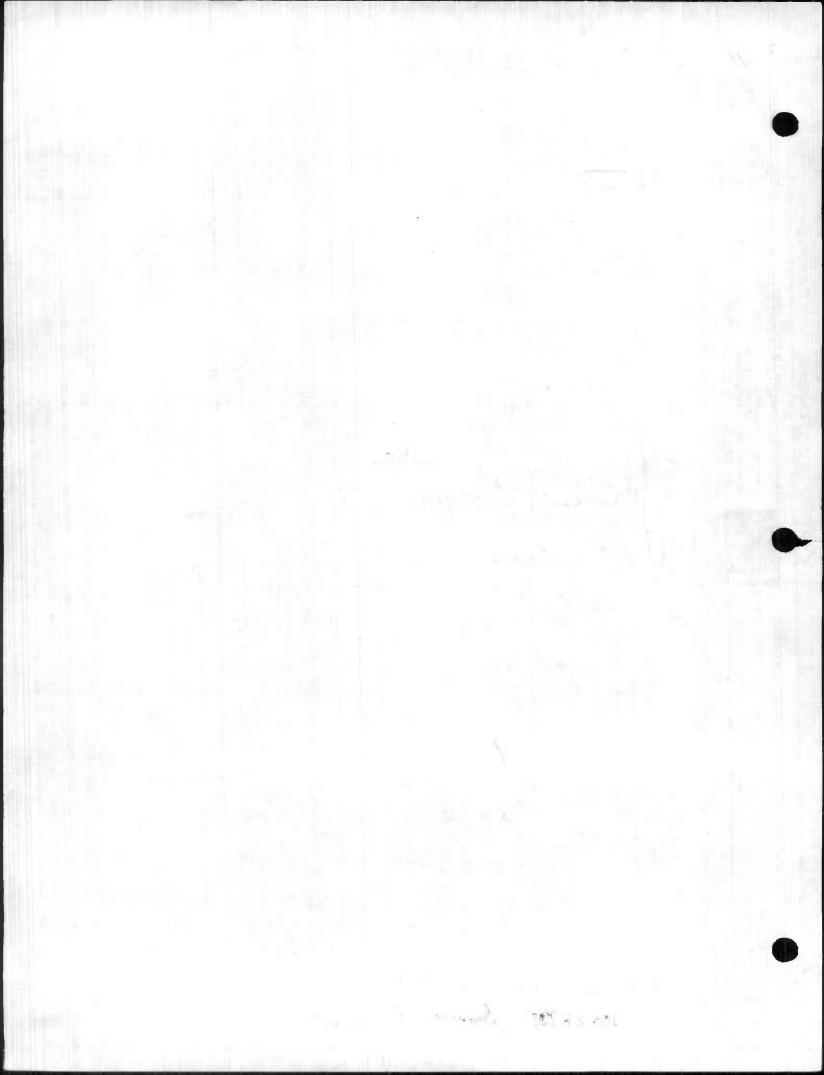
N. Charles 32. Registrer's Signeture

1 Certifying Phyaician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and menner stated.

29c. License number

29d. Dete signed (Month, Day, Year) 22

00



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Deeth **Physician** Month Glenna June White /Medical January 23 2000 1:00 am 4a. Fecility Neme (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Deeth **Examiner** 914 Freeman Street Baltimore n/a If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Social Security Number If Under 1 Yeer 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) Funeral Months 1□ M 200 F Deys 220-20-5724 72 Yrs. Director June 23, 1927 W. Virginia Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Md. N/A Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 914 Freeman Street 21225 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 10 No If Yes, Give Yeer or Dates: 11. Maritel Stetus Was Decedent of Hispenic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 Never Married 2 Merried 1 ☐ Yes 2 ☑ No Specify: þ 3th Widowed 4 □ Divorced White Completed 15. Decadent's Education (Specify only highest grede completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 6th 0 Seamstress Sewing Factory 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Melden Surneme) permit. Pages 1 and 2 should be filk Department of Health end Mental Hy Important: if Item 27 is marked oth any lojury or other traumatic event anse Charles Glen Judy Martha Sponaugle 19e. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Virginia K. Buckelew (Daughter) 5327 Sweet Air Road Baldwin, Maryland 21013 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Green Mount Crematory 1/25/00 Baltimore, Maryland 22. Name and Address of Facility
McCully-Polyniak Funeral Home, P.A. 21. Signature of Juneral Service Licensee 237 E. Patapsco Avenue Baltimore, Maryl and 21225 shock, or head feilure. List only one cause on each line. Approximate Interval Between Onset end Deeth Physician ABDOMINAL AORTIC ANEURYSM mediete Ceuse (Finel RUPTURE Immediate Ceuse (F disease or condition resulting in deeth) **Examiner** Due to (or es a consequence of) Examiner DISSECTING ANEURYSM THORACIC Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in deeth) Lest Due to (or es e consequenca of): TEMPORAL ARTERITIS Physiclan/Medical Due to (or as e consequence of): Pert II. Other eignificent conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Dfd tobacco use contribute to the cause of death? COPD 1 Yes 2 No 3 □ Probably 4 Unknown by GARTRITIS 24b. Were eutopsy findings evelleble prior to completion of cause of death? Completed CHRONIC 24e. Wes en eutopsy performed? 1 Yes 2 No 1 ☐ Yes 2 No Be 25. Wes case referred to medical exeminer? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 KResidenca 6 Other (Specify) Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Menner of Deeth 28e. Dete of Injury (Month, Day Year) 28c. Injury et Work? 28b. Time of 28d. Describe how Injury occurred 1 Netural 5 Pending investigation 1 TYes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide edical 15 Certifying Physicfan: To the best of my knowledge, deeth occurred et the time, dete end placa, end due to the cause(s) and menner es steted.

2 Medical Examinar: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date and place, end due to the cause(s) end menner steted. 29a. Certifier 29b. Signature and title of certifier

A - C. Channelit, mb 29c. License number 29d. Date signed (Month, Dey, Year) 24 2000 00016306

DHMH 16 Rev 6/95

Registrar

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Hygiene.

altimore, Maryland 21215-0020

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The law requires that Records,

page 2

24 hours after deeth.

5 Funeral Director: After this letely filled in by the funeral

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Hospital

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Box

P.O.

of Vital Physician:

Division or Attanding physician and s the burial-transit

the Medical Examiner must be notified at

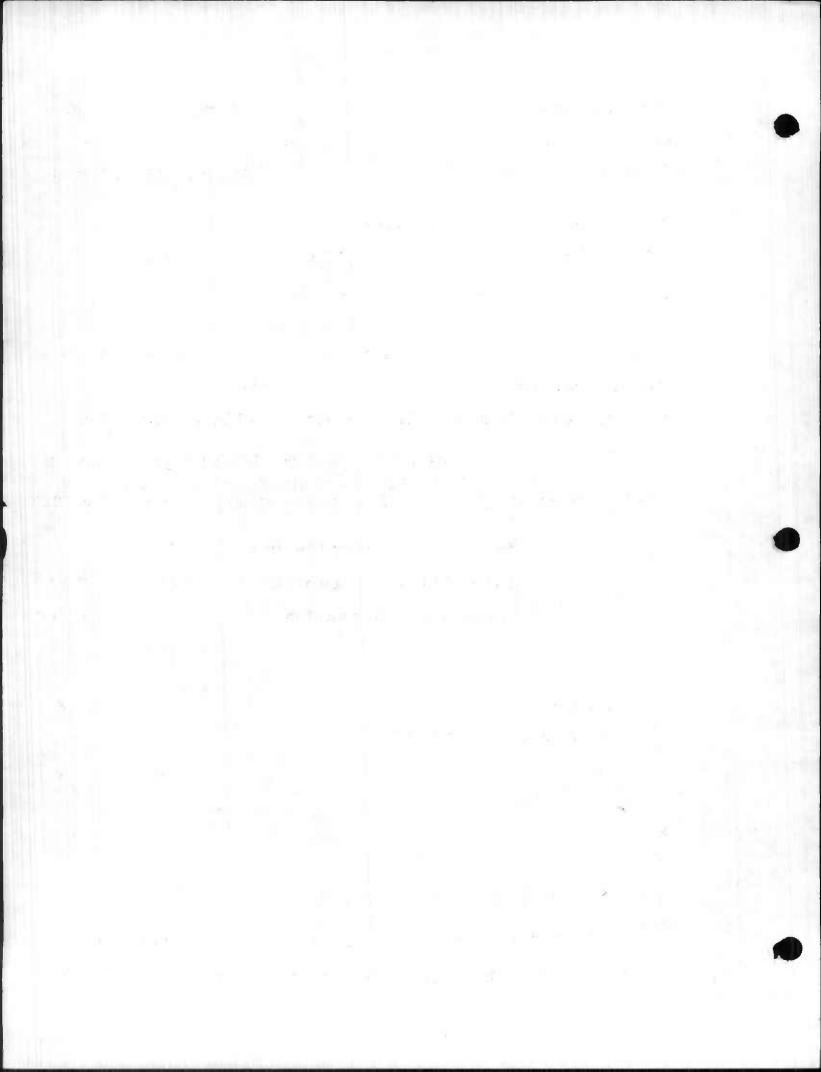
31. Dete tiled (Month, Dey, Year) JAN 2 8 2000

32. Registrer's Signature



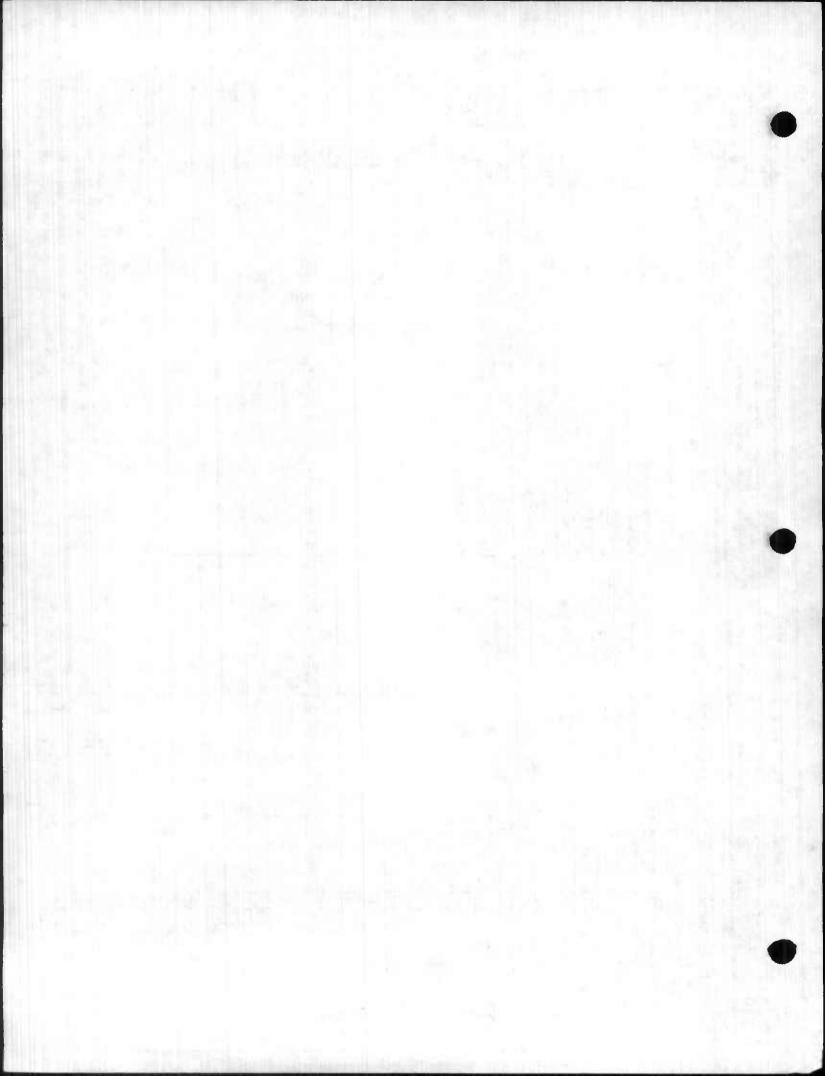
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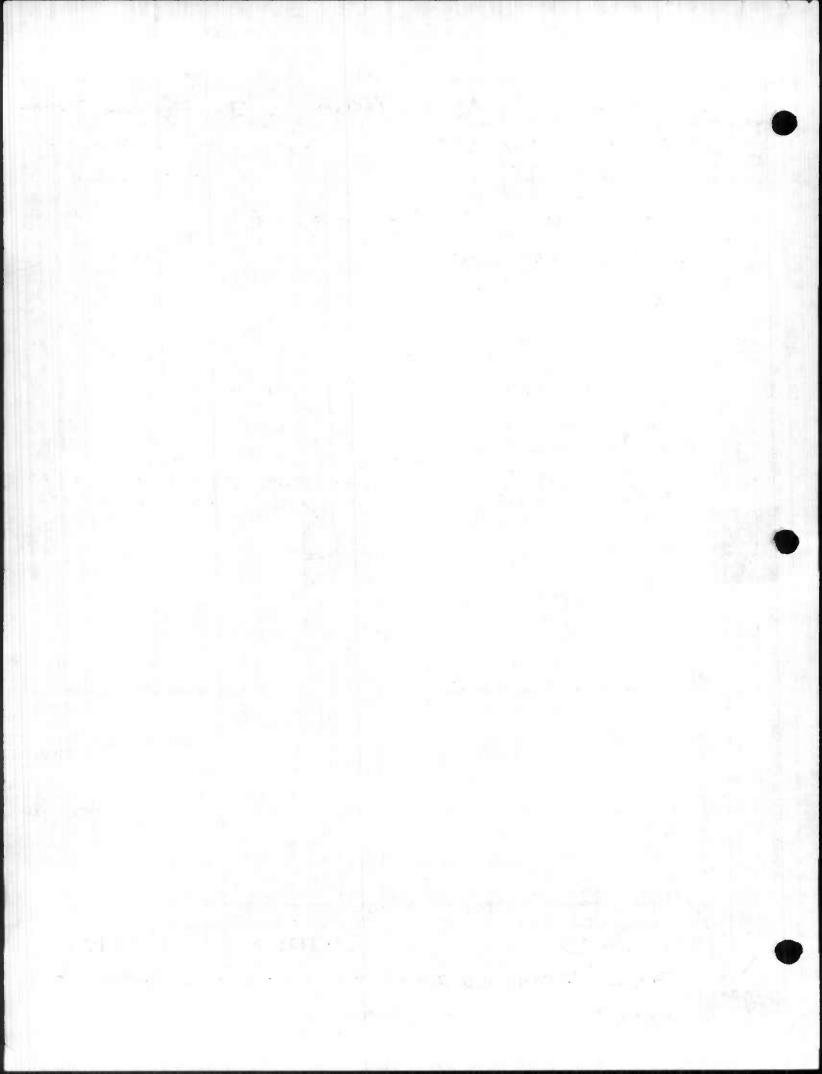
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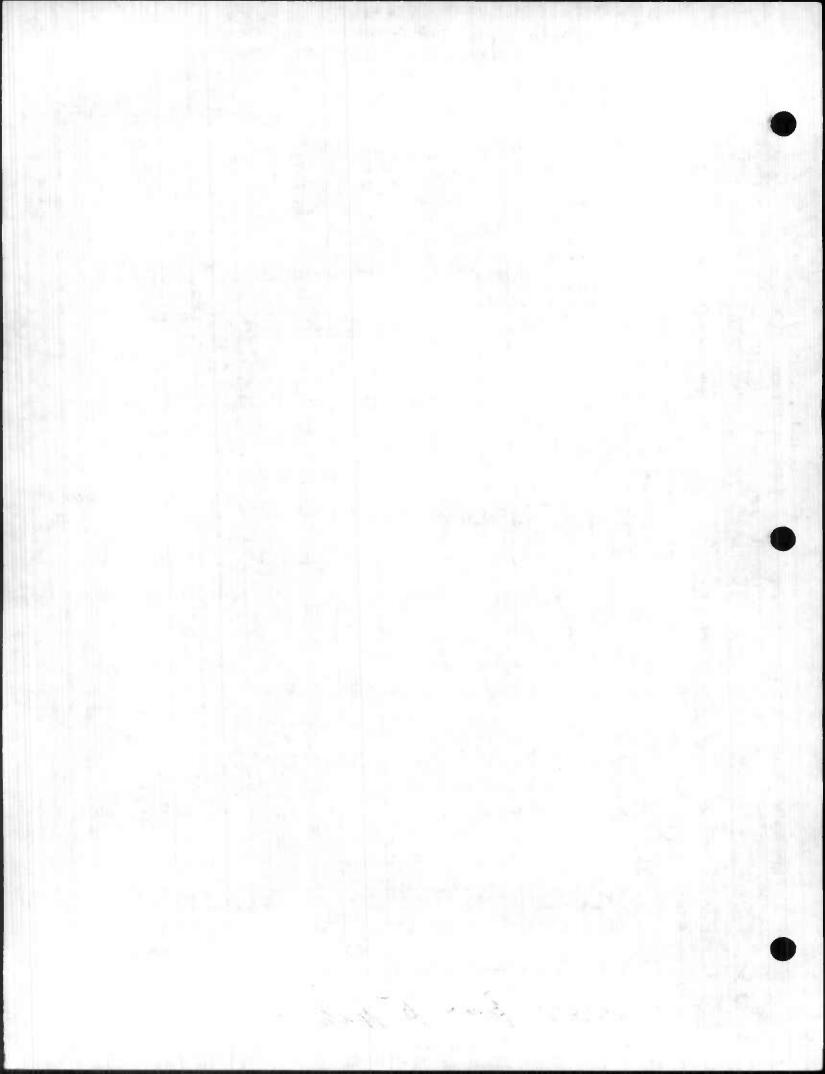


State of Maryland / Department of Health and Mental Hygiene 0 00105

| | | | | | . , | Certific | ate of Death | id mornar rry | Reg. No. | 02133 | |
|--------------------|---|------------------|---|--|--------------------------|----------------------------|---|--|------------------------|---|--|
| | Ohusia | lan. | 1. Decedent's Neme (First, Middle, L | ast) | | | | 2. Dete of De Month | ath | 3. Time of Deeth | |
| | Physic /Medi | | Elena | Α | | W | elsh | Jan | 23rd 20 | 100 7:20 hu | |
|) | Exami | | 4e. Fecility Neme (If not institution, g | ve street end number) | | | 4b. City, Town | , or Location of Deeth | | Death | |
| | | | STELLA MAI 5. Societ Security Number 6. | RIS HOSI | DICE | | Timor | 14m 1110 | BAL | TIMORE | |
| | Funeral | | | Sex 7. Age 1□ M 2⊠,F | (In yrs. lest bii | | der 1 Year If Under 24 ns Days Hours | Hrs. 8. Dete of Bin Min. (Month, De | th y. Year) 9. | . Birthplece (State or Foreign Country) | |
| | Director | | 213-03-6287 | 1L M 424 | 86 | Yrs. | | JAN. 14 | 11913 | ITALY | |
| | pus * | | Usuel Residence of Decedent 10e. Stete 10b. County | | 10d Jacida City I Imite | | | | | | |
| | ahow | 5 | | | 10c. City, Tow | | | 1 1 | | 10d. Inside City Limits 1 ☑ Yes 2 ☐ No | |
| | with the Maryland a or 28a-f ahow Le notified at | ect | Md N/ | 4 | 1512 | LTIN | ORE M | (4. | 40- 02 | | |
| | A P | 2 | | | | | | | 10g. Citizen of Whe | | |
| | deeth w | Funeral Director | 6205 WALTE | 12. Was Decedent E | | 13 Was Do | 21206 | | US 14 Baces | > /4 American Indian, | |
| _ | | E | 1 Never Married 2 Married | Armed Forces? | | If Yes, s | cedent of Hispentc Origin pecify Cuban, Mexican, F | uerto Rican, etc.) | Bleck, 1 | White, etc. | |
| 5-0020 | hours efter ural', or its | by | 3 ⊠Widowed 4 □ Divorced | If Yes, Give Year or Detes: | | 1 □ Yes | 2⊠.No Specify: | | Specify: \ | NHITE | |
| Ö | 72 hours "natural", | 8 | 15. Decedent's E | Education | 16a. | Decedent's U | suel Occupetion | | 16b. Kind of Busin | iess/Industry | |
| 215 | | Completed | (Specify only highest gi Elementery/Secondery (0-12) | rade completed) College (1-4or 5+ | | (Give kind of life. DO NO: | work done during most of use retired) | f working | | | |
| 2 | d withir giene. rr than | E | 12 | 10/4 | , | Home | MAKER | Hom | · E | | |
| D | al Hygie other | Be | 17. Father's Neme (First, Middle, Les | | | | | | Meiden Sumeme) | | |
| Maryland | should be nd Mental marked o | 70 | UNK VER | YNK | | | | | | | |
| a | end end is me | - | 19a. Informent's Neme/Reletionship | (Type, Print) | 19b | | ess (Street end Number o | or Rurel Route Number | er, City or Town, Ste | ete, Zip Code) | |
| _ | | | DANIEL WEL | SH / SOA | 9 | 017 | RED STON | E Rd. Ki | NGSVILL | = Md 21087 | |
| Baltimore | of He | | 20e. Method of Disposition 1. Suriat 2 Cremetion 3 l | TRamqual from State | 20b. Plece of cemete. | f Disposition (I | Veme of or other plece) | Dete | 20c. Location - Cit | y or Town, Stete | |
| E | Peg ment ant: I | | 4 □ Donetion 5 □ Other (Spec | | PARH | woot | CEM. | | BALTO | Md. | |
| alt | pemit. Peges 1 end Department of Health Important: If Itam 27 any Injury or other tr once. | | 21. Signeture of Funeral Service Lice | nade // | | 22. Name | end Address of Facility | IFP Funil | ERAI HO | ME, CHTD. | |
| m | 88 5 8 | | Do High | Ball. | Md. 21234 | | | | | | |
| | | | 23a. Pelt1. Enter the discarte, or con shock, or heart feilure. List only | nplications that caused to | he deeth. Do | not enter the m | node of dying, such es ca | rdlec or respiretory er | rest, | Approximete | |
| | Physician | | SHOOK, OF HOUR TOHING LIST OFF | One cease on each line | 4 | | | | | Intervel Between Onset end Deeth | |
| | /Medical | | Immediate Cause (Finel disease or condition | | | | | | | | |
| | Examiner | | resulting in deeth) | | | | | | | | |
| | p # | Examiner | | | | | | | | | |
| | requires that the death certificate be executed teen signed by the attending physician end hould be detached for use as the bunel-transit | me | Sequentially list conditions, | D | ue to (or es e | consequenca | of): | | | | |
| က္လွ် | oe ex | | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury | C | | | | | | | |
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| o | that the de- led by the a detached f | Physician/ | Pert II. Other significant conditions | contributing to death but | not resulting Ir | the underlyin | g cause given in Pert I. | 23b. Did (| obacco use contri | bute to the cause of death? | |
| 0.0 | that the ed by detay | | | | | | | 10 | Yee 2□ No 3[| ☐ Probably 4 ☐ Unknown | |
| Records, | signed be def | d by | | | | | | 247 W | | 4b. Were autopsy findings | |
| Ö | been si should | Completed | | | | | | | an eutopsy 2 med? 2 | aveileble prior to completion of cause | |
| Je Je | hes ye 2 | ď | | | | | | | | of death? | |
| | cate he | | | 1 | | | | 101 | res 2 PNo | 1 ☐ Yes 2 ☐ No | |
| \rightarrow | Physician: The this certificate rail director, page | Be | 25. Wes case referred to medical exeminer? | Hospitel: | | , | Others | Deeth (Check only o | - | I le | |
| of Vital | Phys this ral di | : To | 1 Yes 2 No | 1 L Inpatient | | tpetient 3 | DOA 4 Nursii | ng Home 5 Resid | lence 6 Other (| Specify) (TUSINCE | |
| 5 | After fune | tion | 1 ☑Naturat 5 ☐ Pending | 28e. Dete of Injury (Month, Dey | Year) | njury M | 28c. Injury et Work? 1 Yes 2 No | 200. Describe i | low injury occurred | | |
| Division | deat ctor: y the | Certification: | 3 Sulcide 6 Could not t | | v - At home fe | | | 28f Location /5 | Street and Number of | or Rurel Route Number, | |
| <u> </u> | efter Olre | ert | 4 ☐ Homlcide determined | 28e. Plece of Injury building, etc. | (Specify) | 1111, 311001, 1001 | ory, omce | City or Tow | | r riare: rioute realiber, | |
| | spita nours neral | | 29a. Certifier 1 Certifying Pl | nysician: To the best of | mv knowledge | , death occurre | ed et the time, dete end p | lace and due to the | Causa(s) and mann | ar as eleted | |
| - | To the Hospital or Attending Ph within 24 hours efter death. To the Funeral Director: After th completely filled in by the funeral | edical | (Check only 2 Medical Example) | miner: On the basis of e | xeminetion and | d/or Investigeti | on, In my opinion, deeth | occurred et the time, | dete end pleca, and | due to the cause(s) | |
| | Vithir To th | Me | 29b. Signature and title of cartifier | | | 2 | 29c. License number | | 29d. Dete signed (A | fonth, Dey, Year) | |
| | 0 | | 1 /mm- | | | | D43725 | | 112 | 4100 | |
| | | | 30. Name and address of person who | completed cause of dea | eth (Item 23e) (| Type, Print) | | | | 1100 | |
| | | | | ALMOUR | 201 | -109 | Back Rive | - Necle R | d Balt | 4100 Imore M12/24 | |
| | Sta | te | 31. Dete filed (Month, Dey, Yeer) | 32. Registrar | | 1 | | | | وي | |
| | Registr | | INN 0 9 2000 | Benero | 19 | Loon the | / | | | | |



| | | Decedent's Name (First, A | fiddle, Last) | | | | | | Death | 2. Date of De | Reg. No. | Year | 3. Time of Deal |
|--|------------------------------------|---|--|--|---|--|--|---|--|--|---|-----------------------------|--|
| cian Iical | | Ray Lee Winters | | | | | | | | JAN | | 200 | 7:55 A |
| ner | 40 | 4a Facility Name (If not institution, give street and number) | | | | | | | 4b. City, Town, or I | | | | |
| | | | RUN | | OSPI | | If I la day | | SIEN B | DRNIE | AA | | |
| | 2: | 217-38-3163 183 M 2 F 59 Yrs. Month | | | | | | Days | Hours Min. | 8. Date of Bir (Month, Da Sept. | 2, 1940 | 9. Birthi Coul West | place (State or For ntry) Virgini |
| | | Usual Rasidence of Decedent 10a. State 10b. County 10c. City, Town or Location Maryland Anne Arundel Odenton | | | | | | | | | | 1 | 10d. Inside City Lin |
| tor | Ma | | | | | | | | | | | | 1 ☐ Yes 2 ₹ |
| rec | 106 | . Street and Number | | | | | 101. Zip | Code | | | 10g. Citizen of \ | What Cou | ntry? |
| natural, or Herra 23a or 28a-f a Meal Examiner must be notified sted by Funeral Director | 14 | 1482 Burger Rd. 21 | | | | | | 13 | | | United : | State | es |
| | | Marital Status 1 □ Never Married 2 □ 3 □ Widowed 4 ☒ Divo | Married | 12. Was Decede Armed Force 1 Yes 2 If Yes, Give Yeer or Date | s? ⊠ No | in U,S. 13. Was Decedent of Hispantc Origin? If Yes, specify Cuban, Mexican, Pue 1 □ Yes 2 ☒ No Specify: | | | | pecify Yes or No Rican, etc.) | Specify | ck, White, | can Indian, etc. |
| | | 15. Deca | edent's Educ | cation | itton 16a. Decedent's I | | | nt's Usual Occupation | | | | usiness/In | dustry |
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| - | | 8 | | | | Contractor | | | | | Const | | lon |
| De completed | 17. | Father's Name (First, Mic | | | | | | | 18. Mother's Nan | | | 10) | |
| 0 | - | Freeman Winters Edna Rodeheaver 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, | | | | | | | | | | | |
| | | a. tnformant's Name/Rela | | | | | | | | | | | o Code) |
| | _ | ay Lee Winte | rs / | Son | 20b. F | | | | Rd., Gler | Date | 20c. Location | | own State |
| | 200 | 1 ☐ Burial 2 🏻 Cremat | emoval from Sta | (e) | Place of Dispos cemetery, crem | | | | Jan. 28 | | | , Maryla | |
| | 21 | 4 Donation 5 Othe Signature of Furniral Ser | | 10 | Me. | tro Cre | | | 2110. | | | | , Maryra |
| | Kirkley-Ruddick Funeral Home, P.A. | | | | | | | | | | | 21061 | |
| edical Examiner | Se If a cal Ca tha res | quentially list conditions, ny, leading to immediate use. Enter Underlying use (Disease or Injury I initiated events ulting in death) Last | \ | Athe | | or as e consequ | uence of): | on. | Art C | uy D. | scase | | Zmanth |
| Physician/M | | | | l | | | | | | | | 1 | |
| Physic | Par | Part II. Other significant conditions contributing to death but not resulting in the un | | | | | | ause gi | en in Part I. | | Did tobecco use contribute to the cause of deat | | |
| ò | - | 2_10 | n emil | Anemia | | | | | | | | T | |
| | | | | Anem | io | | | | | 24a. Was | an autopsy ormed? | an | Pere autopsy tindin vailable prior to emplation of cause death? |
| pierec | - | | | | | | | | | | | | |
| Completed | - | | * | | | | | | | 10 | Yee 25 No | 1 | Yes 20 No |
| Be Completed | 25. | Was case rafarred to me examiner? | dical | | | | | | 26. Place of Da | | | 1 | □Yes 2⊠No |
| | 25. | Was case rafarred to me examiner? 1 ☐ Yes 2 ☑ No Manner of Death 1 ☑ Naturat 5 ☐ Pe | dical H | lospital: 1 □ Inpi | atient 2 | ER/Outpatient 28b. Time of Injury | 3 DC | 8c. Inju | nar: 4 Nursing H | ome 5 Res | | ner (Speci | |
| To Be | 25. | Was case referred to me examiner? 1 Yes 2 No Manner of Death 1 Naturat 5 Pe 2 Accident in | dical H | lospital: 1 Inpe | atient 2 Day Year) | ER/Outpatient | 3 DO | 8c. Inju Wo | nar: 4 Nursing H ny at rk? | ome 5 Resi | one) idence 6 Oth how injury occur | ner (Speci | |
| 0 00 | 25. | Was case rafarred to me examiner? 1 Yes 2 No Manner of Death 1 Naturat 5 Pe 2 Accident in 3 Suicide 6 Cd 4 Homicide de | dical H anding restigation ould not be tarmined | 28a. Date of language. 28a. Place of building. | atient 2 anipury Day Year) Injury - At hetc. (Special st of my knot of examina | ER/Outpatient 28b. Time of Injury ome, farm, stre | M 2 DCC M 2 DC | 8c. Inju Wo 1 , office | nar: 4 Nursing H ny at rk? | ome 5 ☐ Resi 28d. Dascribe 28f. Location (City or To) | idence 6 Oth how injury occur Street and Numi wn, State) cause(s) and m | ner (Special red ber or Rur | (fy) (a) Route Number, |
| 0 00 | 25. | Was case rafarred to me examiner? 1 Yes 2 No Manner of Death 1 Maturat 5 Pe 2 Accident 3 Suicide 6 Cc 4 Homicide a. Certifier 1 Cert (Check only 2 Medi | dical Honding restigation build not be tarmined | 28a. Date of Input 28a. Place of building. 28e. Place of building. | atient 2 anipury Day Year) Injury - At hetc. (Special st of my knot of examina | ER/Outpatient 28b. Time of Injury ome, farm, stre | M 2 M 2 DO 2 M 2 DO 2 DO 2 DO 2 DO 2 DO | 8c. Inju | nar: 4 □ Nursing H ry at rk? I Yes 2 □ No me, date and place | ome 5 ☐ Resi 28d. Dascribe 28f. Location (City or To) | idence 6 Oth how injury occur Street and Numi wn, State) cause(s) and m | ner (Speciared | ral Route Number, stated. to the cause(s) |
| o Be | 25. | Was case rafarred to me examiner? I yes 2 No Manner of Death I Naturat 5 Pe 2 Accident in a Suicide 6 Co 4 Homicide de a. Certifier (Check only one) | onding restigation uid not be tarmined litying Physical Examir | 28a. Date of Input 28a. Place of building. 28e. Place of building. | atient 2 2 Injury Day Year) Injury - At hefc. (Specification of my known of examine statad. | ER/Outpatient 28b. Time of Injury ome, farm, stre | M 2 M 2 DO 2 M 2 DO 2 DO 2 DO 2 DO 2 DO | 8c. Inju Wo | nar: 4 Nursing F ry at rk? Yes 2 No me, date and place spinion, death occu | ome 5 ☐ Resi 28d. Dascribe 28f. Location (City or To) | idence 6 Oth how injury occur Street and Numi wn, State) cause(s) and m date and place, | ner (Speciared | ral Route Number, stated. to the cause(s) |



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Month Year 8:05 am Wilderson 26,2000 Margaret MAC 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death eW Geriatrics

7. Age (In yrs. last birthday)

| Winder 1 Year | Min. | Min. | Min. | Month, Days | Min. | Sept. | 20 | 1903 Johns Hopkins Bayview Geriatrics NA 9. Birthplace (State or Foreign Country)
3 Illinois 1□ M 2□F 216-01-5590 Usual Rasidance of Decedent 10c. City, Town or Location 10a. Stata 10d. Inside City Limits Baltimore Maryland NA 1 Yas 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 5505 Bayview Circle 21224 U.S. of America 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, Bleck, Whita, atc. 1 Never Married 2 Married 1 Yas 2 No 1 ☐ Yes Z No Specify: Specify: 3X Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementary/Secondery (0-12) College (1-4or 5+) Secretary Laundry 17. Fathar's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Peter Burke Katherine Ryan 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Author Burke (Brother) 1100 Dundalk Ave. Balto., Md. 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata Jan. 1 Burial 2 Cramation 3 Removal from State Sacred Heart of Mary Dundalk, Maryland 29 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Nama and Address of Facility W. Dabrowski-Chojnacki F.H.'s P.A. 6 10 1005 Dundalk Ave. Ba clused the death to not enter the mode of dying, such as cardiac or respiratory arrest, each line. 1005 Dundalk Ave. Balto., Md. 21224 23a. Partt. Enter the disease, or shock, or heart failure. List Immediata Causa (Final Zweeks disaasa or condition rasulting in deeth) Due to (or as a consequence of) 8 years ementic Sequentially list conditions, if any, laading to immediata cause. Entar Underlying Cause (Diseesa or injury that initiated evants rasulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did lobacco use contribute to the cause of death? 1 Yes 2 VNo 3 Probably 4 Unknown 24b. Ware autopsy findings available prior to 24a. Wes an autopsy performed? completion of cause of death? 1 Yas 1 ☐ Yas 2 ☐ No 25. Was case refarred to medical axaminar? 26. Place of Death (Check only one) 1 Yas 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Horna 5 Residence 6 Othar (Specify) 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 Accidant 5 Pending 1 Yes 2 No Invastigetion 3 Suicide 6 Could not be detarmined 28e. Plece of Injury - At homa, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 ☐ Homleide 29a. Certifier 13 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of axaminetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Physician Examiner The law requires that the death certificate be executed P.O. Box 68760, Records, Division of Vital f or Attending Physician; after death.
Director: After this certifica To the Hospital within 24 hours a To the Funeral C

Baltimore, Maryland 21215-0020

Ulbderson

Mantal B Is merked

Department of Health a Important: If Nem 27 Is any injury or other tra

/Medical

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certificate

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Medical Certification: To

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must be n

State Registrar

DHMH 16 Rev 6/95

29b. Signatura and titla of certifier

Crystal Simpson M.D.

31. Date filed (Month, Dey, Year)

JAN 2 8 2000

32. Regi

· Cuptal Simpaon M. 20.

30. Name and addrass of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

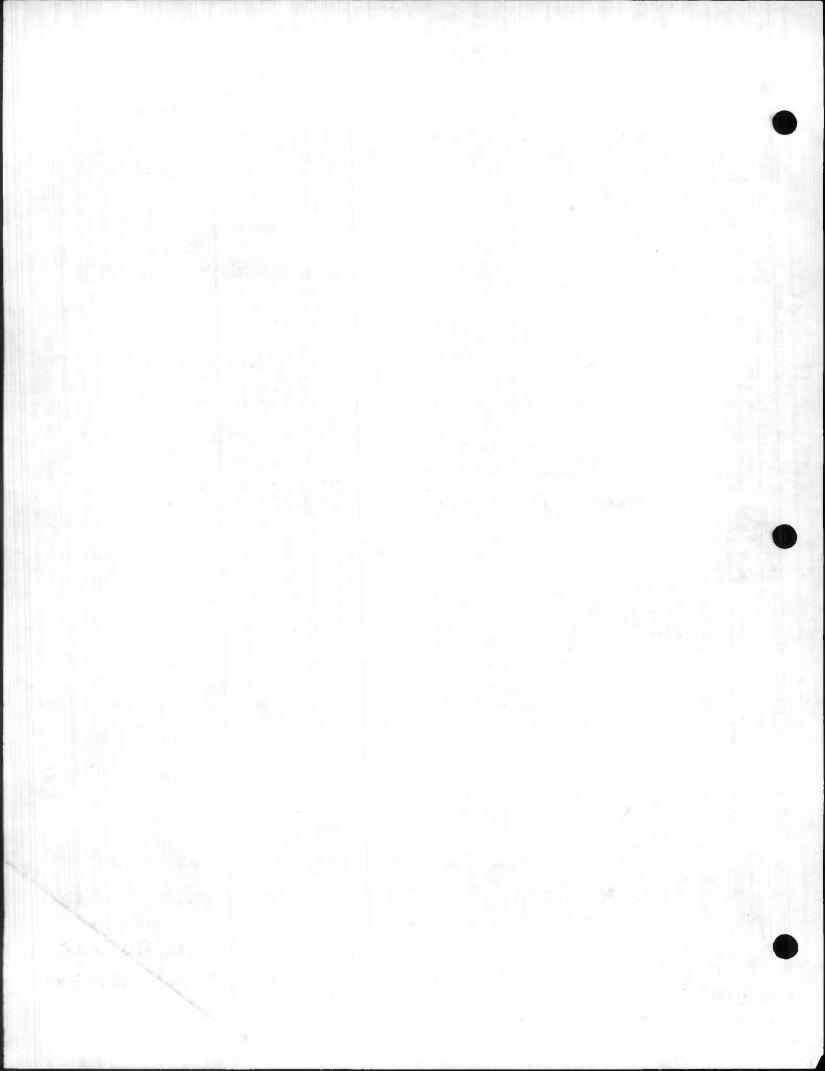
5505 Hodens Baywiew Circle Baltimore MD 21224 parks

29c. License number

054502

29d. Date signed (Month, Day, Year)

Jan 26 2000



P.O. Box 68760, Records, Division of Vital

UHARton

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director; I

29b. Signature and titla of certifiar 30. Name and addrass of person who completed causa of death (Item 23a) (Type, Print)

ill M

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Data signed (Month, Day, Year) 301 Hospital Drive, Glen Burnie 21061

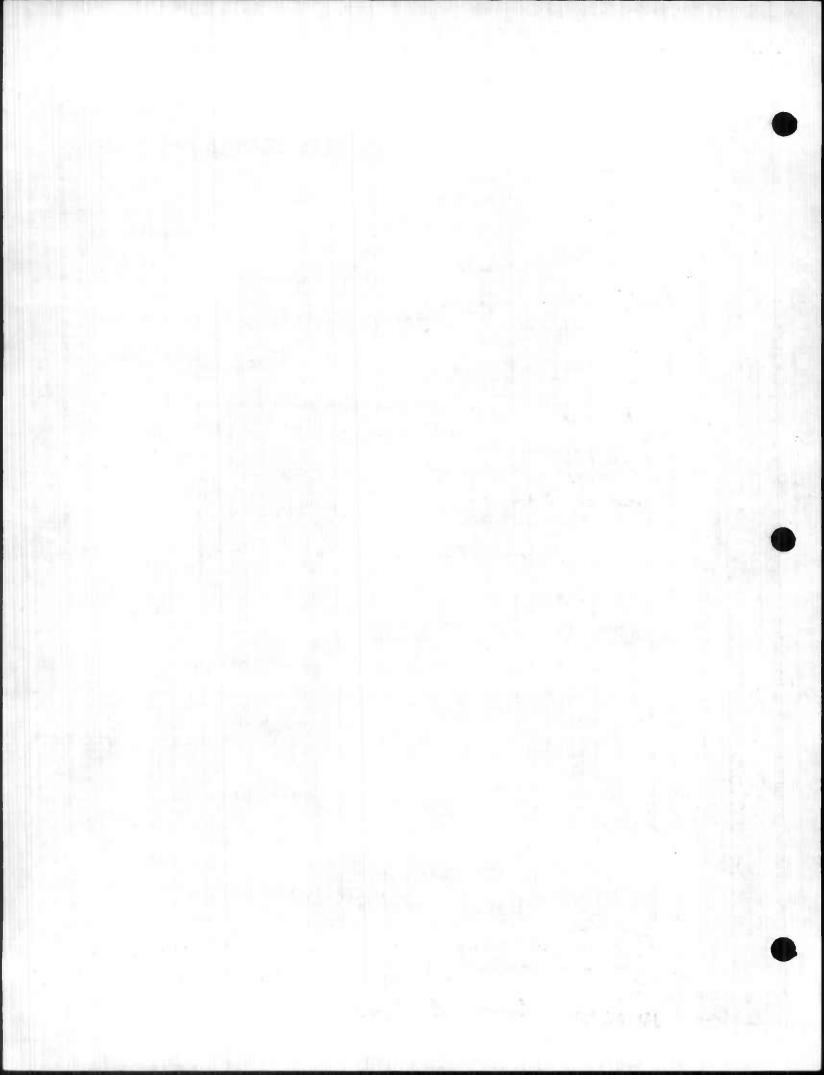
George E. Wicks 31. Data filed (Month, Dey, Year)

29a. Certifier

IAN 28 2000

32: Registrar's Signatura

State Registrar

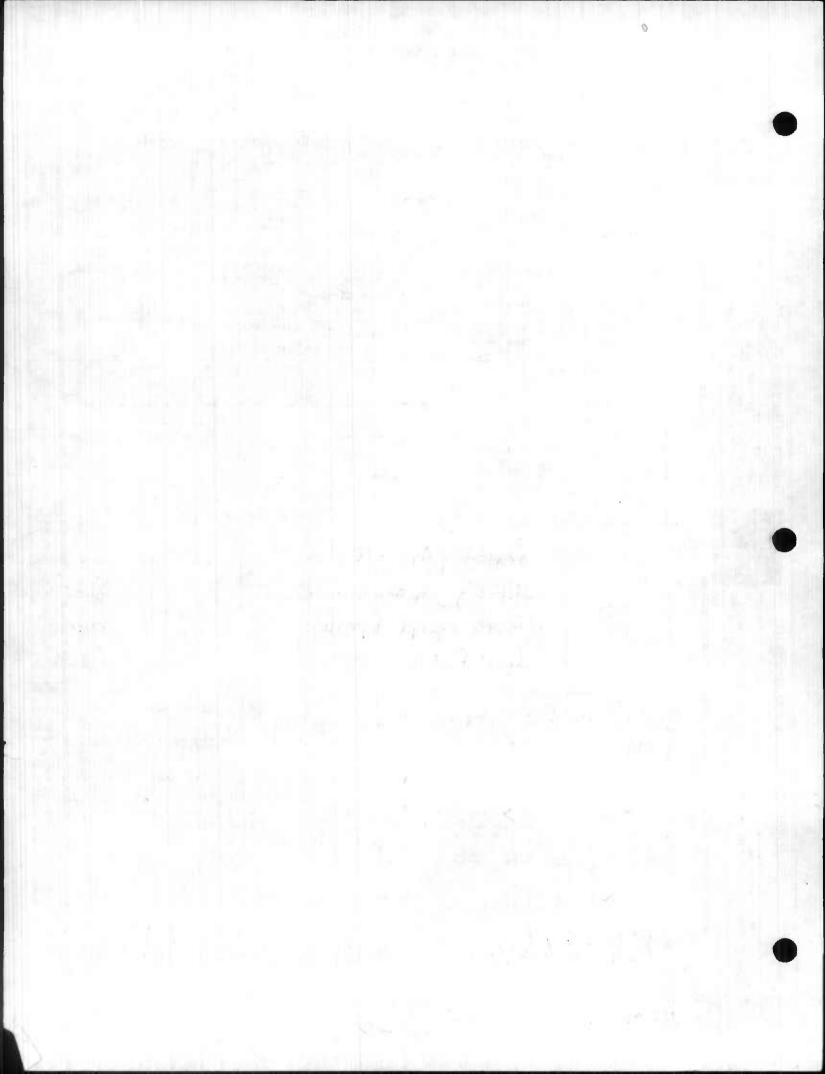


Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death little Day **Physician** 18, 2000 4c. County of Death 1456 01 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltmore Social Security Number 6. Sex 7. Age (In yrs. last birthday) If U Baltimore H Under 24 Hrs. Hours Min. 8. Data of Birth (Month, Day, Year)
June 18, 1926 If Under 1 Year Months Days 5. Social Security Number Birthplace (Stata or Foreign Country)
 West Virginia **Funeral** 10 M 25 F Days 236-42-0006 Director Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City. Town or Location ahow 10d. Inside City Limits 1 Yes 2 No Director Virginia Frederick Winchester notifie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? frems 23s or 2 With 22602 U.S.A. 106 Huntcrest Circle Completed by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 1 Yes 2 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puerto Rican, atc.) 14 Race - American Indian 11 Marital Status Pages 1 and 2 should be illed within 72 hours after dinant of Health and Mental Hygiene.
snt: If Item 27 le merked other than "natural", or them
ury or other traumetic event, the Medical Examination. Black, Whita, atc. 1 Never Married 2 Married 21215-0020 1 ☐ Yes 2 No Specify: White Specify 3√Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Drug Store Elementary/Secondary (0-12) College (1-4or 5+) Fountain Mgr.&Pharmacy Clerk Baltlmore, Maryland 18. Mother's Nama (First, Middle, Maiden Surnama) 17. Father's Name (First, Middle, Last) Charles A. Pennington Pearl Humes 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1320 Wickell Rd. Odenton, Maryland 21113 Maynard L. Wratchford 20b. Place of Disposition (Nama of cometery, crematory or other place)
Shenandoah Memorial Park 20a. Method of Disposition 20c. Location - City or Town, Stata 1- Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If eny Injury or 01/21/2000 Winchester, Virginia 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Nama and Addrass of Facility Jones Funeral Home, Inc. 228 S. Pleasant Valley Road Winchester, Virginia 22601 M00535 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart leilure. List only one cause on each line. Intarval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Fespiration Hmes Examiner Due to (ar as a consequence Examiner Multicogen system for physician and the budal-transit The law requires that the death certificate be assouted Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) c encephalopathy Due to (or as a consequence of): Box 68760, Physician/Medical that initiated events resulting in death) Last for usa as Fallere Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. P.0. 23b. Did tobacco use contribute to the cause of death? Atrial 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Medical Certification: To Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? After this certificate has 2 DINO 200 No 1 Yes 1 🗆 Yas or Attending Physician: funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1) Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation To the Hospital or Attendit within 24 hours after death. To the Funerel Director: A 1 Yas 2 No 2 Accident 9 6 Could not be 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 3 ☐ Suicide 281. Location (Street and Number or Rural Routa Number, City or Town, State) filled in by 4 Homicide Legislativing Physician: To the best of my knowledge, death occurred at the time, data and place, end due to the cause(s) and manner as stated. 29a, Certifie completely reor: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. (Check only 29b. Signatury 29c. License number 29d. Date signed (Month, Day, Year) ted cause of death (Item 23a) (Type, Print) 31. Data filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 16 Rev 6/95

Registrar

2 8 2000



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** CLYDE YOUNG, JR. January 19, 2000 10:10PM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4e Facility Neme (If not institution, give street end number) Examiner VA MARYLAND HEALTH CARE SYSTEM PERRY POINT CECIL 8. Dete of Birth Nov. Year) If Under 1 Yeer | If Under 24 Hrs. 5. Sociel Security Number Birthpiece (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Deys Hours Min XDM 2DF 74 247-30-1448 Yrs. 1925 S.C. Director Usual Residence of Decedent 72 hours after death with the Maryland 10e. Stete 10b. County 10c. City, Town or Location 10d. Ineide City Limits r 28a-f show MD BALTIMORE 1 ☐ Yes 2 ☑ No PIKESVILLE Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ir than "natural", or items 23a or the Medical Examiner must be 6608 SANZO ROAD 21209 Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1♥2 Yes 2 □ No If Yes, Give Yeer or Detes: 14. Race - American Indien, Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Bleck, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: BLACK þ 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) filed within Etementary/Secondary (0-12) Coffege (1-4or 5+) Pages 1 and 2 should be filed within nent of Health end Mental Hygiene.
int: if item 27 is marked other than 12th LABORER CONSTRUCTION CO. 18. Mother's Neme (First, Middle, Melden Sumeme) 17. Father's Neme (First, Middle, Last) Be CLYDE YOUNG, SR. SARA YOUNG 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) TERRY YOUNG - SON 6608 SANZO RD PIKESVILLE, MD 21209 20b. Piece of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Dete 1 Burial 2 ☐ Cremetion 3 ☐ Removel from State = 8 Department of Important; If any Injury or GARRISON FOREST VETERANS 1-27-00 OWINGS MILLS, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funerei Service Licensee 22. Name and Address of Fecility MARCH FUNERAL HOME WEST, INC. 4300 WABASH AVE. 21215 BALTO., MD Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, or heart arilure. List only one cause on each line. Approximate Intervat Between Onset end Death Physician /Medical Immediate Ceuse (Finel End Stage Chronic Obstructive Pulmonary Disease Unknown diseese or condition resulting in deeth) Examiner Due to (or es e consequence of): Examiner Unknown Cardiomyopathy physician and the burial-transit law requires that the death certificete be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initieted events resulting to deeth) Lest Due to (or es e consequence of): Unknown Sepsis P.O. Box 68760 Physician/Medical Due to (or es e consequence of): 98 been signed by the s should be deteched Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown Division of Vitai Records, þ 24b. Were eutopsy findings aveileble prior to completion of cause of death? Completed 24a. Wes en eutopsy certificate has lirector, page 2 : 1 Yes 2 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: director, Be 25. Wes case referred to medical exeminer? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) To 1 Yes 2 No 1 Nnpatient 2 ER/Outpatient 3 DOA this funeral 28e. Date of Injury (Month, Dey Yeer) 27. Manner of Deeth 28d. Describe how Injury occurred Certification: 28b. Time of 28c. Injury at Work? After 1 Neturel 5 Pending efter death. 1 Yes 2 No investigetion 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide • Funeral 1 Certifying Phyeician: To the best of my knowledge, deeth occurred et the time, dete end piece, and due to the cause(s) end manner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date end pieca, and due to the cause(s) end menner stated. within 24 hou To the Funer completely fil 29e. Certifier edical To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture end title of certifier January 19, 2000 D39170 30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print)

VA Maryland Health Care System, Perry Point, MD 21902

State Registrar RAKESH MATHUR, M.D.,

JAN 28 2000

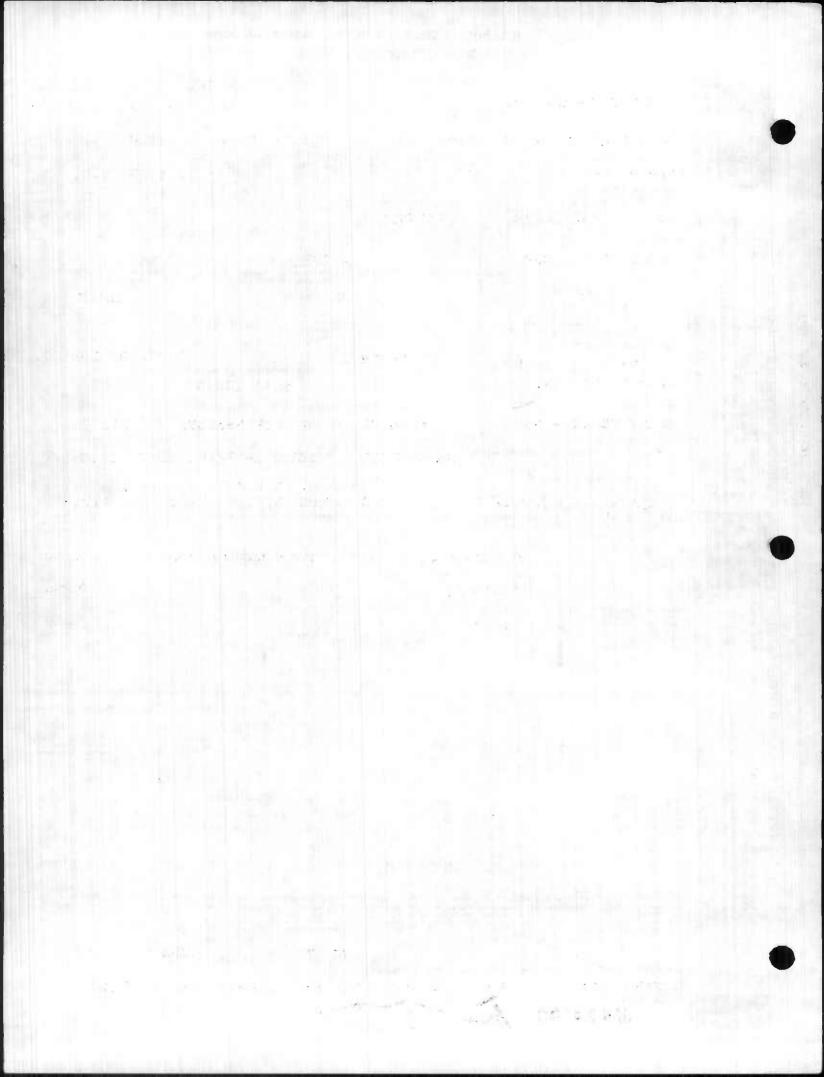
intrer's Signeture

31. Dete filed (Month, Day, Year)

PHYSICIAN

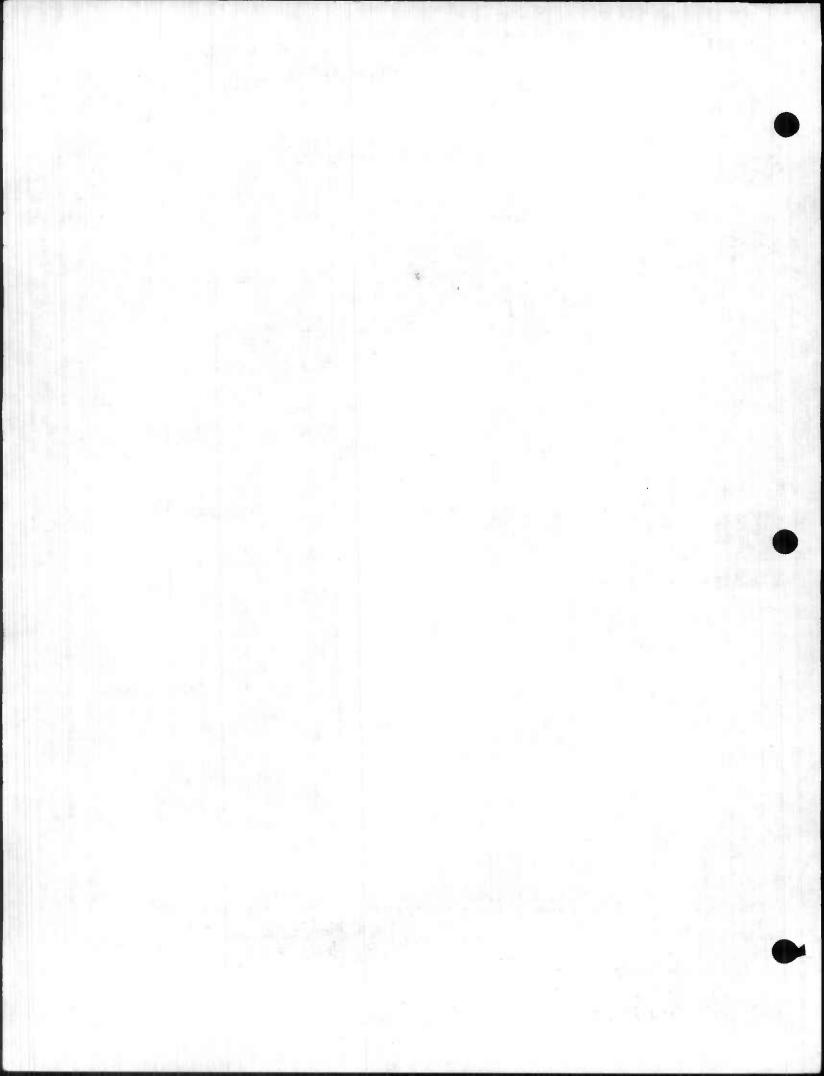
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NAME KNOWN



State of Maryland / Department of Health and Mental Hygiene 0 0 2 1 1

| | Certificate of Death | F | Reg. No. | tion 1 Tr | | | | | | | | | |
|--|--|--|---|--|--|--|--|--|--|--|--|--|--|
| | 1. Decedent's Name (First, Middle, Last) | ith Name | 3. Time of Death | | | | | | | | | | |
| Physician | LEWIS YATES | Jan 2 | 3 2000 Year | 8:54am | | | | | | | | | |
| /Medical Examiner | 4a Facility Name (If not institution, give street and number) 4b. City, Ton | wn, or Location of Death | | | | | | | | | | | |
| CAMINICI | 8 Manifold Court | dia Dirram | D= 1 t d | | | | | | | | | | |
| Funcion | 5. Social Security Number 8. Sex 7. Aga (In vrs. last birthdey) If Under 1 Yaar If Under | dle River 24 Hrs. 8. Date of Birth | Baltimo | | | | | | | | | | |
| Funeral Director | 215-16-4007 | Min. 8. Date of Birth (Month, De) NOV • 6 | 1922 MAI | placa (State or Foreign ntry) Cyland | | | | | | | | | |
| 2 | Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location | | | 10d. Inside City Limits | | | | | | | | | |
| th with the Maryla 23s or 28s-f sho ust be notified at ral Director | | e river | | 1 ☐ Yes 2 🕱 No | | | | | | | | | |
| 41 th | 10e. Street and Number 10f. Zip Code | | 10g. Citizen of What Cou | ntry? | | | | | | | | | |
| at the Co | 0 Man 2 C = 4 3 O = 1 | USA | | | | | | | | | | | |
| her death or thems 23 kiner must | 11. Marifal Status 12. Was Decedant Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Oring figures (1) (1) (2) (2) (3) (4) (4) (4) (4) (4) (4) (4) (4) (4) (4 | | | | | | | | | | | | |
| by by | 3 Wildowed 4 □ Divorced Year or Dates: 1 ☐ Yes 2 ☑ No Specify: | , Puerto Rican, etc.) | to Rican, etc.) Black, White, e Specify: W | | | | | | | | | | |
| D of the B | 15. Decedent's Education 16a. Decedent's Usual Occupation | | 16b. Kind of Business/In | ndustry | | | | | | | | | |
| 21215-0 ed within 72 ho vg fann. var than 'natur r, the Medical. Completed | (Specify only highest grade completed) (Give kind of work done during most life. DO NOT use retired) | | | | | | | | | | | | |
| om the population of | Elementary/Secondary (0-12) Collega (1-4or 5+) Electrician | 4 | America Tota | al Izator | | | | | | | | | |
| D HERE O | | r's Name (First, Middle, | Maiden Sumema) | | | | | | | | | | |
| Maryland d 2 should be lile th and Mental Hy 7 is marked othe traumatic event. | | | | | | | | | | | | | |
| S partie of | P.O. | Marvella | | | | | | | | | | | |
| S S S S S S S S S S S S S S S S S S S | 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number) | er or Rural Route Numbe | r, City or Town, Stete, Zij | p Code) | | | | | | | | | |
| 在货帐 > | Russell Yates /son 2525 Windsor Road | Baltimon | re Md. 2123 | 34 | | | | | | | | | |
| 5 - 1 F F F F | 20a. Mathod of Disposition 20b. Place of Disposition (Name of cematery, cremetory or other place) | Date | 20c. Location - City or Te | | | | | | | | | | |
| Saltimore, semit. Pages 1 a spertment of Hes mportant: If Item ny injury or othe mos. | 1 X Burial 2 Cremation 3 IRemoval from State | /26/2000 | Baltimore | MD. | | | | | | | | | |
| inguity a | 21. Signature of Funeral Service Licensee 22. Name and Addrass of Facility | v | | | | | | | | | | | |
| W SOFF | Connelly Funeral Home of Essex | | | | | | | | | | | | |
| 100000000000000000000000000000000000000 | 300 Mace Ave. Baltimore Md 21221 | | | | | | | | | | | | |
| | 23a. Part 1. Enter the disease, or complications that caused the death part of enter the mode of dying, such as shock, or heart failure. List only one cause on each line. | cardiac or respiratory ar | rest, | Approximate Interval Between | | | | | | | | | |
| Physician | | / , | | Onset and Death | | | | | | | | | |
| /Medical | Immediate Cause (Final disease or condition | na HI | (ch) | | | | | | | | | | |
| Examiner | resulting in death) | | | | | | | | | | | | |
| خ المسلم | Immediate Cause (Final disease or condition rasulting in death) Due to (or as a consequence of): Liver facilities | | | | | | | | | | | | |
| 58760, icate be axecuted physician and s the bunel-transit | b. LIVER Sauver | | 1 | | | | | | | | | | |
| Xa Xa | Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): | 1 | | | | | | | | | | | |
| 68760, ificate be ass g physician a as the burial edical Ex | Cause (Disease or Injury C. | | | | | | | | | | | | |
| 6876 ficate be physicials the bu | resulting in death) Last Due to (or as a consequence of): | | | | | | | | | | | | |
| N Sin Pr | | | - | | | | | | | | | | |
| Box eath cert for use | 0. | | 1 | | | | | | | | | | |
| death death death ed for a | Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I | . 23b. Dfd t | obacco use contribute t | to the cause of death? | | | | | | | | | |
| oy th | | 101 | res 2 √00 3 Pro | obably 4 Unknown | | | | | | | | | |
| dS, P.O. BOX ires that the death or signed by the attend d be detached for us d by Physiciary | | | | | | | | | | | | | |
| ords requires een sign hould be | | 24a. Was | an autopsy 24b. W | Vere autopsy findings vailable prior to | | | | | | | | | |
| w require been sit should be | | perfo | C | omplation of causa | | | | | | | | | |
| (D) @ @ (C) | | | 01 | f death? | | | | | | | | | |
| The Page P | | 101 | res 2 No 1 | ☐ Yes 2☐ No | | | | | | | | | |
| f VItal Reysician: The law ysician: The law ysician: The law greector, page 2 director, page 2 fo Be Comp | 25. Was case referred to medical 26. Place | of Death (Check only o | ne) | | | | | | | | | | |
| Of Vita Physician: this certific ral director, | axaminar | 1 | dence 6 Other (Speci | ifu) | | | | | | | | | |
| Physical distriction of the ph | | | now injury occurred | "17 | | | | | | | | | |
| After fune | 27. Manner of Death 28. Date of Injury (Month, Dey Year) 28b. Time of Injury Work? 1 Yes 2 | No | | | | | | | | | | | |
| DIVISION C but or Attending P rs after death. at Director: After ti ed in by the funera Certification: | 2 Accident invastigation 3 Suicide 6 Could not be | | | | | | | | | | | | |
| Division or Attending after death. Director: After din by the fune ertification | 4 Homicide 3 Stilicide 4 Homicide 4 Homicide 4 Stilicide 5 Stilicide 5 Stilicide 5 Stilicide 5 Stilicide 6 Stilicide 7 Stilicide 6 Stilicide 7 Stilicide 6 Stilicide 7 Stilicide 7 Stilicide 8 Stilicide 8 Stilicide 9 Stilic | 281. Location (S City or Tox | Street end Number or Rui vn, Stete) | re/ Houta Number, | | | | | | | | | |
| Central of in | | | | | | | | | | | | | |
| Hospi 14 hou Funer tely fill | 29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date an examination and/or investigation, in my opinion, dea and manner stated. | d place, and due to the other through the time, of the ti | cause(s) and manner as date and place, and due | stated. to the cause(s) | | | | | | | | | |
| To the To the comple | and mainly states. | | 29d. Date signed (Month) | Day Year! | | | | | | | | | |
| F318 | A pulled and title of certained | 01 | 1/ | 2 4 4 2 | | | | | | | | | |
| 10 | 024 | 05 | 1/24/ | 6000 | | | | | | | | | |
| 4) | 30. Name and address of person who completed cause of death (ttem 23a) (Type, Print) | Horpilas | ! Balt | more my | | | | | | | | | |
| | 31 Date filed (Month Day York) 4 20 Decisions Classes | | | 12/5 | | | | | | | | | |
| State Registrar | 31. Date filed (Month, Day, Year) 11 N 2 R 2000 Server 4. | | | | | | | | | | | | |
| neuistrar | THE THE PARTY OF T | | | | | | | | | | | | |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene \(\) Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month Betty 0810 Yanke 25 2000 4e Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death of Baltimore Univ. If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Months Days 220-24-7136 1 M 2 F 70 Yrs. 01-17-1930 MARYLAND Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location BALTIMORE n/a 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1107 BAYARD STREET 21223 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Bleck, White, etc. 1 ☐ Yes 2 No 1 Never Merried 2 Married 1 Yes 2 No Specify: Specify: WHITE 3 Widowed 4 Divorced Yeer or Detes: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 10 HOMEMAKER OWN HOME 17 Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Surname) WILLIAM WIDMYER GRACE SHETTLE 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WALTER WILLIAM YANKE HUSBAND 1107 BAYARD STREET, BALTIMORE, MD 01-28 2000 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other of 20c. Location - City or Town, State 1 X Burial 2 Cremetion 3 Removel from State LOUDON PARK CEMETERY BALTIMORE, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Fundral Service Licensee 22. Name end Address of Facility 4107 WILKENS AVENUE HUBBARD FUNERAL HOME, INC. BALTIMORE, MD 21229 23a. Fart. Enter the disease/or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or hear feiture. List only one cause on each line. Approximate Interval Between Onset and Death Immediete Cause (Finel disease or condition resulting In death) Acute Myocardial Infarction Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Couse (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 PNo 1 Yes 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) 1 Yes 2 No Hospitel: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 PER/Outpatient 3 DOA 27. Menner of Daath 28d. Describe how injury occurred 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 1 Neturel 5 Panding Investigation 1 Yes 2 No 2 Accident 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 6 Could not be determined 3 Sulcide Location (Street and Number or Rural Route Number, City or Town, State)

The law requires that the death certificate be executed and Box 68760. the signed by the atter Division of Vital Records, P.O. or Attending Physician: funeral director. After this

Examiner Physician/Medicai Be Completed by Certification: To To the Hospital or Attendin within 24 hours after death. To the Funeral Director: At completely filled in by the fu death.

Physician

/Medical

Examiner

Funeral

Director

show

280-1

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Pages 1 and 2 should be liled within 72 hours after tent of Health and Mental Hygiene.
Int. If Nem 27 is marked other then "nature", or its

nt of Health a iff Bern 27 is or other tree

Physician

/Medical

Examiner

Baltimore, Maryland 21215-0020

Director

Funeral

Completed by

Be

State Registrar

Medical

31. Dete filed (Month, Day, Year) DHMH 16 Rav 6/95

29b. Signature appl title of certifier

4 | Homicide

(Check only one)

2 Medical Exam

af

29a. Certifier



30. Neme and address of person who completed cause of death (Item 23a) (Type, Print)

Baltimere

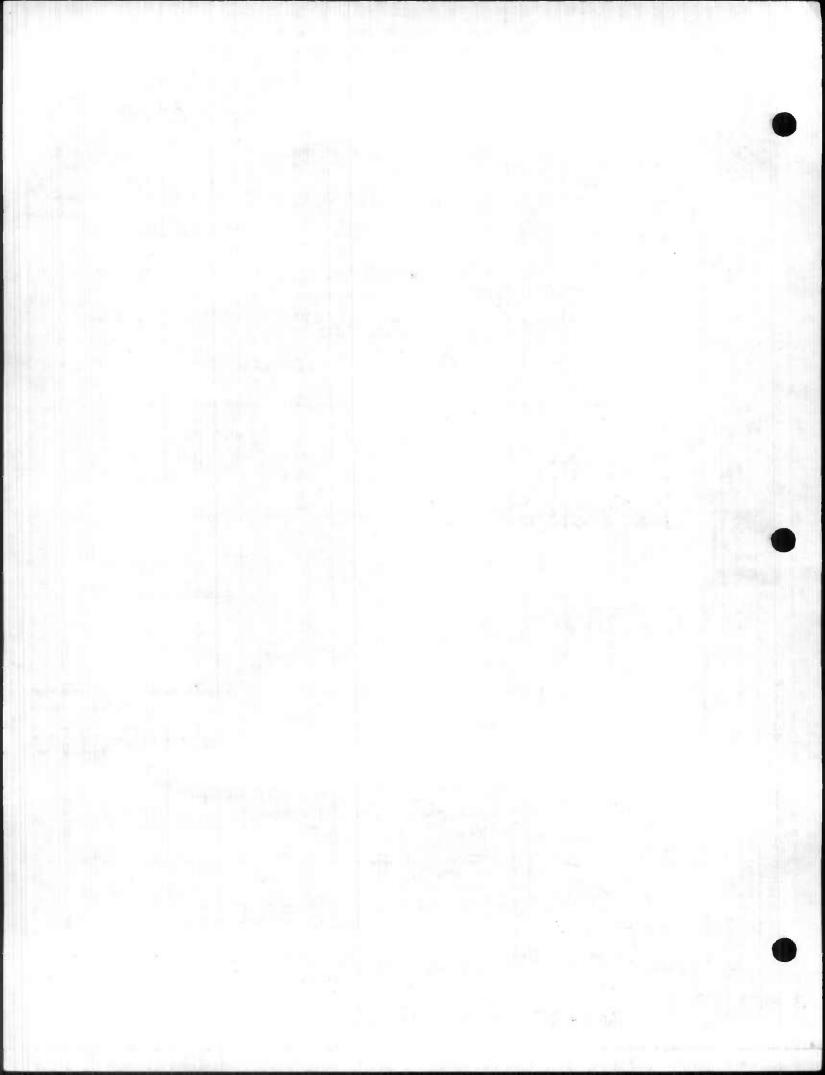
1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner steted.

29c. License number

29d. Dale signed (Month, Day, Year)

WADE GAASCH M.D.

2000



| AMEND ITEMS: | #19B, 20B P | ER F.H. G | | f Marylai 000 WR. | | artmen | | | | Mental H | ygiene Reg. No. | 0 | 021 | 1,3 | |
|---|---|-------------------------------|--|-------------------------|---|----------------------|-----------|-----------------------|---|-----------------------|----------------------|---------------------------|--|-------------------------|--|
| Physician | Decedent's Name (First, Middle, Last) FLORENCE | | | | | 7.TM | MER | MAN | | 2. Dete of I Month | Dey | | eer , | ima of Deeth | |
| /Medical | | | | | | 21. | | | | J- n | | | 0.0 | | |
| Examiner | 4s Facility Name (1 | If not institution, If = 5 p | give street and nur | L Ba | It'm. | - ر | | 66. City, 10 BALTI | | ocation of Dea | ath 4c. C | 4c. County of Death N/A | | | |
| Funeral | 5. Social Security N | lumber (| | 7. Age (In yrs | last birthday) | If Under | | If Under | | 8. Dete of B | Birth | 9 Birthplace (State or Fr | | | |
| Director | 215-82-9 | 9625 | 1□M 2ÅF | 1□M 20F 85 | | Months | Days | Hours | Min. | JUL.3, | 1914 | | Country) | MD | |
| 70 | Usual Residence of | Decedent | | | | | | | | | | | | | |
| 5 Bu | 10a. State | 10b. County | | 10c. C | ity, Town or Lo | cation | | | | Day 9 | | | 10d. In | side City Limit | |
| Man 1 an 1 an 1 an 1 | MD | ВИГТ | IMORE | BA | LTIMORE | 2 | | | | | | | 11 | Yes 2⊠N | |
| or 28a-f be notifies Directo | 10e. Street and Nur | | INONE | DA | PITMORI | | Code | _ | | | 100 Citize | n of Whe | ol Country? | | |
| | 4001 0 | 318 | 10f. Zip Code 21208 | | | | | U.S.A. | | | | | | | |
| her death v thems 23s sher must Funeral | 11. Marital Status 12. Wes Decedent Et Armed Forces? | | | | er in U,S. 13. Was Decedent of Hispanic | | | | ispanic Origin? (Specify Yes or No- in, Mexican, Puerto Rican, etc.) | | | | 14. Rece - American Indian, | | |
| T die | 1 Never Marri | ied 2 Marrie | 2 X No | | | | | | | | | Bleck, White, etc. | | | |
| D | 3XXWidowed | 4 Divorced | e ales: | 1 ☐ Yes 2 ☑ No Specify: | | | | | | S | Specify: WHIT | | HITE | | |
| D 00 100 D | | 15. Decedent's | Education | | 16a Dece | dent's Usua | I Occur | etion | | | 16b. Kind | of Busin | Business/Industry | | |
| 0 F E E | (Spec | | (Give | kind of wor | k done | durina mos | t of work | ing | | | | | | | |
| ad within 72 ho bygiens. Net then "natur it, the Medical. Completed | Elementary/Seco | ndary (0-12) | -4or 5+) | | | | | | | OWN HOME | | | | | |
| O PET O | 17. Father's Name | | HOMEMAKER 18. Mother's Neme | | | | | a /Einst Midd | | | 2 | | | | |
| B 4488 B | | | ist/ | | | | | | | | | umerne) | | | |
| District C | | MORRIS | attill . I | | | KLING | | LEN | | SCHI | | | | | |
| Mar nd 2 sh nd 2 sh nh and 27 is m treum | 19a. Informant's Ne SUSAN M | | p <i>(Type, Print)</i> RMAN / DA | UGHTER | 19b. Meilii 302 I | ng Address E. JOE | (Street | and Numb ROAD | #170 | 1 - BA | STIMO! | Town, Sta | 10, Zip Code 10, Zip Code 10, Zip Code |) 36 | |
| Ten and other other | 20a. Method of Disg | position | | | Pleca of Dispo | | | na! | | Dete | | ation - Cit | City or Town, State | | |
| Page ment of ury or | 1 Burial 2 Donation | | H TFILOH CEMETERY 1-26-2000 WOODLAWN, MD | | | | | | | | | | | | |
| pemit Depart Import any in | V////V/VX | | | | | | | | | | EVINSON & BROS., INC | | | | |
| | 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21200 | | | | | | | | | | | | | | |
| Physician | Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Shock, or heart failure. List only one cadse on each line. Approximate Intervel Between Onset end Deeth | | | | | | | | | | | | | | |
| /Medical | Immediate Cause (Finel disease or condition | | | | | | | | | | | | t t | | |
| Examiner | disease or condition a. He was hag, c 5 to ke Due to (or as a consequence of): | | | | | | | | | | | | 1 | | |
| i i | | | | | | | | | | | | | 1 | | |
| outed ransk | | | b/ | | | | | | | | | | 1 | | |
| exacute tin end dei-tram | Sequentially list con if any, leading to im | nmediate | | Due to (| or as a consec | quence or): | | | | | | | 1 | | |
| | cause. Enter Unde Cause (Disease or | injury | C | | | | | | | | | | į | | |
| floate be physical the bu | that initiated events resulting in death) I | Last | | Due to (| or as a conseq | uenca of): | | | | | | | | | |
| Seth certificate attending physical for use as the iclan/Medic | | | | | | | | | | | | | | | |
| th cert | | | - 0 | | | | | | | | | | | | |
| deeth deeth adforte | Part II. Other signif | icant condition | s contributing to de | ath but not re | sulting In the u | nderlying ca | ause giv | en in Pert | l. | 23b. Di | d tobacco u | aa contri | bute to the | ause of deati | |
| as, F.C. BOX. The the death certification of the destroy of the estending by Physician/M. | | | | | | | _ | | | 1[| Yes 2 | No 3 | Probably | 4 Unkno | |
| - 5 50 × | | | | | | | | | | | | | | . ,,,, | |
| requires sen sign hould be sted by | | | | | | | | | | 24e. We | es en eutops | v 2 | 24b. Were au | topsy findings | |
| v require been si should is | | | | | | | | | | | rformed? | | complet | prior to on of cause | |
| hes the | | | | | | | | | | | | | of death | ? | |
| The lew requir | | | | | | | | | | 10 | Yes 2 | No | 1 Yas | 2□ No | |
| certificate rector, per | 25. Was case refer | red to medical | | | | | | 26. Place | a of Dee | th (Check only | y one) | | | | |
| Physician: this certification and director. | examiner? | No | Hospitat: | npatient 2 |] ER/Outpatier | nt 3 DO | A Oth | er. | | oma 5□Re | | Other | (Specify) | | |
| ng Phys ther this unenei di | 27. Manner of Death 1 Available 1 Death 28a. Date of Injury 28b. Time of Injury 28b. Injury at Work? | | | | | | | | | 28d. Describ | | | | | |

Division of

N

U

Medical Certification:

To the Hospital or Attending Physicial 24 hours effectesh.
To the Funeral Director: Affectials completely filled in by the funeral di

DHMH 16 Rev 6/95

State Registrar

31. Date filed (Month, Day, Year) JAN 2 8 2000

29b. Signature, and title of certifier

2 Accident

3 Suicide

29a. Certifier (Check only one)

4 Homicide

5 Pending investigation

6 ☐ Could not be determined



-, MO

28e. Placa of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

Sparker

29c. License number

RES-000

1 Yes 2 No

ORIGINAL

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as steled.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

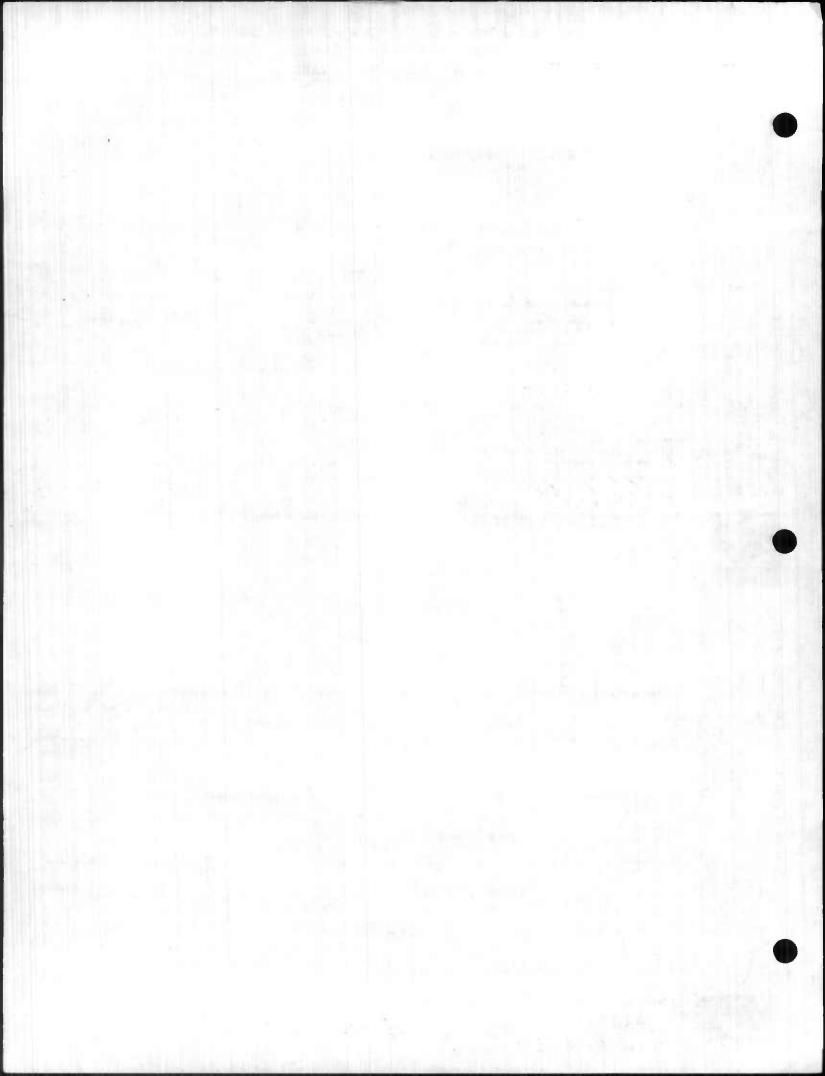
2000

Jonvery 23

28f. Location (Street and Number or Rural Route Number, City or Town, State)

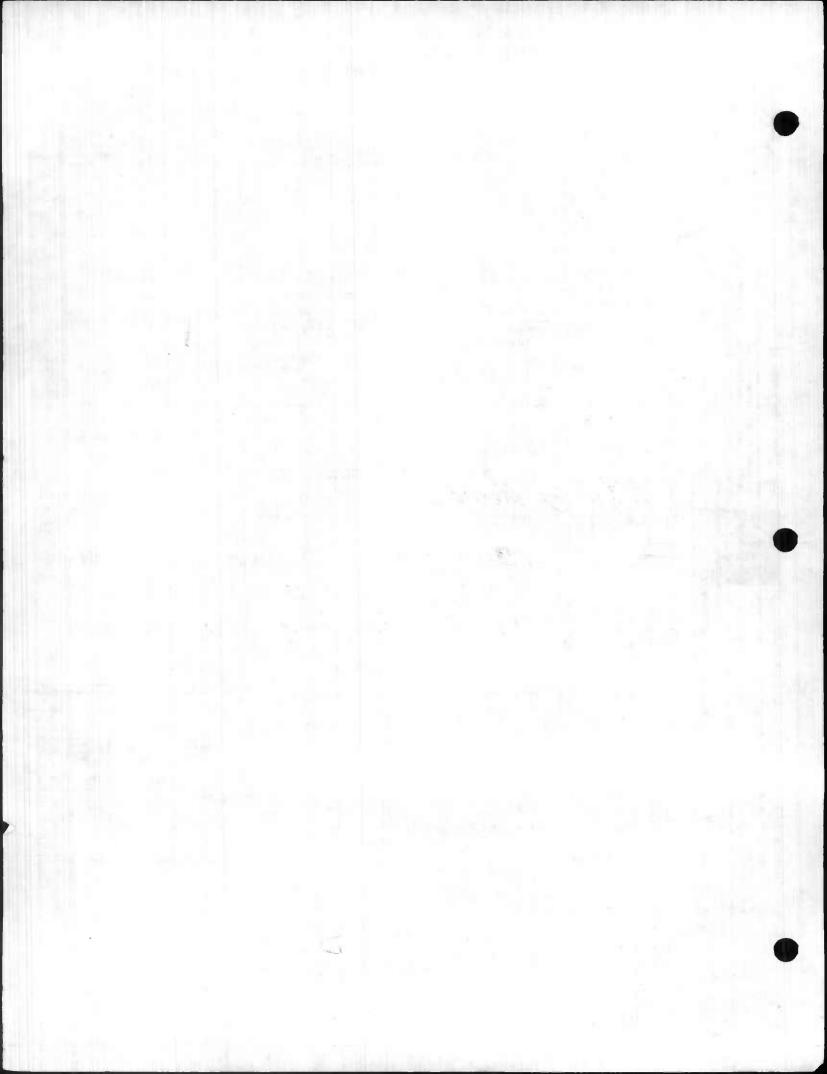
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Tuskin B.o.n., mo Sinai Hospital of Baltimore



State of Maryland / Department of Health and Mental Hygiene 0 2 1 4 4

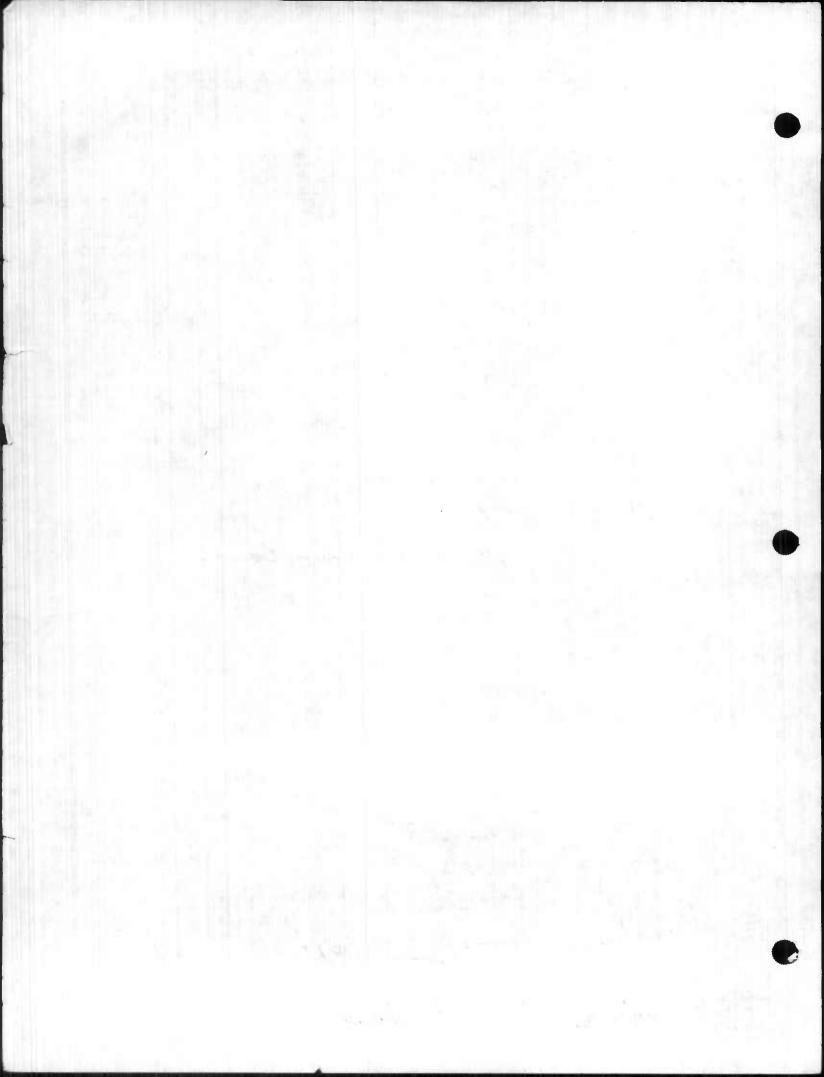
| | Certificate of Death | Reg. No. | | | | | | | | |
|--|--|---|--------|--|--|--|--|--|--|--|
| Dhuaisian | Decedent's Nama (First, Middla, Last) | 2. Data of Death Month Day Year 3. Time of Death | ath | | | | | | | |
| Physician /Medical• | Lawrence Benjamin Zepp | TAN 23 2000 165 | 55 | | | | | | | |
| Examiner | 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or L | ocation of Death 4c. County of Death | | | | | | | | |
| | 1010 | HON AH | | | | | | | | |
| Funeral | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 57 Yrs Months Days Hours Min. | 8. Data of Birth (Month, Day, Year) 9. Birthplace (State or Fo | preign | | | | | | | |
| Director | 577-54-9379 | May, 31 1942 Washington, I | | | | | | | | |
| 2 3 | Usual Rasidence of Decedent 10a. State 10b. County 10c. City, Town or Location | 10d. Inside City L | imite | | | | | | | |
| Anyler Tehow | MD Anne Arundel Churchton | 1 ☐ Yes 2 ☐ | | | | | | | | |
| the M | 10e. Street and Number 10f. Zip Code | 10g. Citizen of What Country? | | | | | | | | |
| flar death with the Maryland r flores 23a or 28a-f show since must be notified at Funeral Director | 1062 Rodgers Road 20733 | USA | | | | | | | | |
| | 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto | pecify Yas or No- o Rican, etc.) 14. Race - American Indian, Black, Whita, atc. | | | | | | | | |
| 020 ura ura by | 1 Never Married 2 Married VXYas 2 No No No No No No No No | Specify: White | | | | | | | | |
| 2 2 2 | 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Giva kind of work done during most of work life. DO NOT use retired) | king 16b. Kind of Business/Industry | | | | | | | | |
| 2121 d within glene. r then | Elementary/Secondary (0-12) College (1-4or 5+) | | | | | | | | | |
| Co Hydled O | 10 Service Mechanic 17. Father's Nama (First, Middle, Last) 18. Mother's Nam | HVAC na (First, Middle, Maiden Surnama) | | | | | | | | |
| Maryland 2 d 2 should be filled th and Mentel Hygle Te aumatic event, a | Benjamin Zepp Rozeli | | | | | | | | | |
| | | aral Routa Number, City or Town, Stata, Zip Code) | | | | | | | | |
| re, Mar 1 and 2 sho 1 Haalh and 16m 27 la m other traum | Lawrence D. Zepp - Son 6516 Delia Drive, Alex | | | | | | | | | |
| re, N s 1 and M Health Rem 27 other tr | 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cematary, crematory or other place) | Data 20c. Location - City or Town, Stata | | | | | | | | |
| | 1 Bunal 22/2/remation 3 Hemoval from Stata | Jan. 26, Baltimore, MD | | | | | | | | |
| Baltimo | 21. Signature of Euperal-Service Licenses 22. Nama and Addrass of Facility | | | | | | | | | |
| 0 88 E 8 8 | balach A Mendal Hardesty Funeral | Home, P.A. e, Annapolis, MD 21401 | | | | | | | | |
| | 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line. | or raspiratory arrest, Approximata | | | | | | | | |
| Physician | | Onset and Dea | | | | | | | | |
| /Medical | Immediata Cause (Final diseasa or condition resulting in death) a. Acute archive Tryline Tryline UN Due to (or as a consequence of): | | | | | | | | | |
| Examiner | resulting in death) Due to (or as a consequence of): | act trerescy are | | | | | | | | |
| 68760, ficeta be executed physician and s the buriet-transit | - Arterioxcleratic Hea | int Disense | | | | | | | | |
| 58760, iceta be executed physician and s the buriel-transit | U | | | | | | | | | |
| 50, se so se | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury c. Chrowic Respired How | 1 DISCASIL | | | | | | | | |
| 68760, liceta be e physician is the burie | that initiated events resulting in death) Last Dua to (or as a consequence of): | | | | | | | | | |
| | d | | | | | | | | | |
| P.O. Box that the death certified by the ettending deteched for use the physician/M | | | | | | | | | | |
| .O. tha de chee | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. | 23b. Did tobacco use contribute to the cause of d | eath? | | | | | | | |
| | | 1 Yea 2 No 3 X Probably 4 Uni | cnown | | | | | | | |
| Records, P ha tew requires that e has been signed b age 2 should be date ompleted by Pl | | 24a. Was an autopsy 24b. Wara autopsy findi | nas | | | | | | | |
| II Record The lew require tate has been si page 2 should Completed | | performed? available prior to completion of caus | | | | | | | | |
| Rec a lew pa 2 si mple | | of death? | | | | | | | | |
| = F & a O | | 1 Yas 2 No | | | | | | | | |
| Of Vital Re Physicien: The it this carificate he ral director, page :: To Be Com | examiner? Hospital: Other | ath (Check only ona) | | | | | | | | |
| Physical direction of Topics of Topi | 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing He | oma 5 Alesidence 8 Othar (Specify) 28d. Describe how injury occurred | | | | | | | | |
| After funa | Natural 5 Pending (Month, Day Year) Injury Work? | 200. Describe from their occurred | | | | | | | | |
| Vision attending or death. | 3 Suicide 6 Could not be | 28f. Location (Street and Number or Rural Routa Number | | | | | | | | |
| Division of the or Attending P as the death. al Director: Attart and in by the funerical in by the funerical or ortification: | 4 Homicide detarmined detarmined building, atc. (Specify) | City or Town, Stata) | | | | | | | | |
| ours Filled | 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, | and due to the cause(s) and manner as stated | | | | | | | | |
| DIVISION O To the Hospital or Atlanding Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral Medical Certification: | (Check only 2 Marting Framines: On the basis of examination and/or investigation in my oninion death occur | red at the time date and place and due to the reuse/s) | | | | | | | | |
| Methic Withir To th | 29b. Signature and title of certifier Deput 1 29c. License number | 29d. Data signed (Month, Day, Year) | | | | | | | | |
| | 1/1/1/ 1 D 060 | 54 1/24/00 | | | | | | | | |
| | 30. Name and address of person who completed come of death (Item 23a) (Type, Print) | | | | | | | | | |
| (V) | William P. JONES, MD 695 An | merie A 21035 | | | | | | | | |
| State | 31. Data filed (Month, Day, Year) 32 Registrar's Signatura | | | | | | | | | |
| Registrar | 29b. Signature and title of certifier 29b. Signature and title of certifier 29c. License number 29d. Data signed (Month, Day, Year) 30. Name and address of person who completed coase of death (Item 23a) (Type, Print) 31. Data filed (Month, Day, Year) 32. Registrar's Signatura 33. Aparlls 34. Aparlls | | | | | | | | | |



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 02145

| | | | Ce | rtificate | of Dea | ith | R | eg. No. | | C 1 00 | |
|--|--|---|--|---|---------------------------|--|---|---|--|---|--|
| | 1. Decedent'a Name (First, Middle, Las | t) | | | | | 2. Date of Deat Month | | Yeer | 3. Time of Death | |
| Physician | Edwin Allan Zimm | rerman, Jr. | | | | | January | 22 20 | 000 | 9:05PM | |
| /Medical Examiner | 4e Facility Name (If not institution, giva 13710 Summerhill Dr. | | | | | y, Town, or L enix | ocation of Death | 4c. County Baltim | of Deeth | | |
| Funeral Director | 21/-14-6320 | 7. Age | (In yrs. last birthday) 87 Yrs. | If Undar 1 Y | Year If U | ndar 24 Hrs. urs Min. | 8. Date of Birth (Month, Dev. Sept. 9 | of Birth 9. Birthplace (State or Formula) 9. Birthplace (State or Formula) Maryland | | | |
| f show ad at Or | Usual Residence of Decedent 10m. State 10b. County MD. Baltimore | | 10c. City, Town or Lo | ocation | | | 1 | | 1 | 0d. Inside City Limit | |
| a or 28a-fs | 10e. Street and Number 13710 Summerhill D | | 10f. Zip Co | | | 1 | 10g. Citizen of What Country? | | | | |
| natural, or terms 23a or 28e-f show dical Examiner must be notified at eted by Funeral Director | 11. Marital Status 1 Naver Married 2 Merried 3 Widowed 4 Divorced | 12. Was Decedent E Armed Forces? 1 Yas 2 N If Yes, Give Year or Dates: | | | t of Hispani Cuban, Me | c Origin? (Sp xican, Puarto ecity: | pecify Yas or No- Rican, etc.) | 14. Rac | e - Amaric ck, White, | | |
| *natural edical | 15. Decedent's Edi (Specify only highest grad | | (Give | dent's Usual O kind of work of DO NOT use r | done during | most of worl | king | 16b. Kind of Bu | usiness/in | dustry | |
| than the king | Elementary/Secondery (0-12) | College (1-4or 5 | +) | Presider | | | | MD. Natio | onal | | |
| Be sell | 17. Father's Name (First, Middle, Last) Edwin Allan Zimmerme | | | | Mother's Nem ula He | na (First, Middle, I nderson | Maiden Surnan | ne) | | | |
| and N | 19a. Informant's Neme/Reletionship (T | | 1 | | | | rel Poute Number | | State, Zip | Code) | |
| Health em 27 other tr | Mrs. Barbara Zimmermar 20a. Method of Disposition | n/ Wife | 20b. Place of Disp | | of | . Phoen | ix, MD. 21 | 21131 20c. Location - City or Town, State | | | |
| Department of I important: If the any injury or o once. | 1X Burial 2 Cremation 3 1 |) | Clynmalina | Methodi | ist Cem | | -26-00 | Phoenix | , MD. | | |
| Depar Import | 21. Signature of Funeral Service Licen | 600 | 00 2 | 2. Name end A RUC 105 | k Tows | on Funer | ral Home, wson, MD. | Inc. 21204 | | | |
| Medical kaminer | Immediate Cause (Final disease or condition resulting in death) | | Due to (or as a conse | | Graen | - 6 | ancel | | at a second seco | | |
| attending physician and I for use as the burial-transit clan/Medical Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or Injury that initieted events resulting in death) Last | C | Due to (or es a conse | | | | | | | | |
| d by the attend etached for us Physician/ | Part II. Other significant conditions co | ntributing to deeth bu | ut not resulting in the underlying cause given in Part I. 23b. Did tobacco | | | | | bacco use co | cco use contributa to the cause of de | | |
| igned by the be detached by Physic | | | | | | | 1 🗆 Y | es 2 No | 3 Pro | bebly 4 Unkn | |
| should should | | | | | | | 24a. Wes a perform | n autopsy med? | av | are autopsy finding allable prior to impletion of cause death? | |
| page 2 | | | | | | | 10 Y | es 2 No | 11 | ☐Yas 2☐ No | |
| h. After this certificate funeral director, par tion: To Be Co | 25. Was case refarred to medical exeminer? 1 Yes 2 No 27. Menner of Deeth 1 Neturet 5 Pending | Hospitel: 1 Inpatie | | of 28c. | Other: 4 | □ Nursing H | ome 5 Residence 28d. Describe h | ence 6 DOth | | 'y) | |
| within 24 hours after death. To the Funeral Director. After the transcompletely filled in by the funeral Medical Certification: | 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Pleca of Injury - At home, ferm, street, fectory building, etc. (Specify) | | | | | 2 No | 28t. Location (S City or Town | treet and Numi n, State) | ber or Run | al Route Number, | |
| A hour Funer tely fill | | | f my knowledge, deel examinetion and/or in ted. | | | | | | | | |
| To the comple | 29b. Signature and title of certifier | | | | icansa num | | | 9d. Data signe | | Dey, Year) | |
| | 30. Name and address of person who c | completed payse of d | em/(Item 23a) (Type | , Print) | 7 | 106 | 29 4 | lork | P | 1. | |
| | 31. Date filed (Month, Dey, Year) | . 17 / | Of HNC ir's Signeture | 0/11/16 | 0,1 | 000 | 1 / / | 011) | re | 1. | |



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** January 28,2000 Year NORMAN L. BOYKIN 5 am /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1302 Greyswood Rd. Odenton Anne Arundel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Dete of Birth (Month, Day, Year) **Funeral** Months 449-84-8709 1€ M 2□ F 52 Director JUne 8,1947 Usuat Residence of Decedeni 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or frame 23a or 28a-l ahow the Hedical Examiner must be notified at Director Md. Anne Arundel Odenton Nayes 2□No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 1302 Greyswood 21113 USA Rd. Funeral 12. Wes Decedent Ever in U,S.
Aymed Forces?
1 ☐ Yes 2 ☐ No
If Yes, Give
Year or Detes: Viet Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Stetus 14. Race - American Indian, Bleck, White, etc. permit. Pages 1 and 2 should be filed within 72 hours efter (Department of Health end Mentel Hygiena. Important: if item 27 is marked other than "natural", or his any injury or other traumatic event, the Healtes Examination. 1 Never Merried 2 Married 1□ Yes 2√3No Specify: Specify: American Indian P 3 Widowed 4 Divorced Nam Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Contractor Home Improvement 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be Norman L. Boykin Elizabeth Cox 19a. Informent's Neme/Retetionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Norma K. Moreland / wife same as 10e 20b. Place of Disposition (Name of cemetery, crematory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Huntt Crematory January 30,2000 Waldorf, Md. 4 ☐ Donation 5 ☐ Other (Specify)
Signature of Fundal Server License 21. Signali 22. Name end Address of Fecility Robert E. Evans Funeral Home, Inc 16000 Annapolis Rd., Bowie, Md. 20715 23a. Part 1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intervat Between Onset and Death Physician fmmediete Cause (Finat disease or condition resulting in deeth) /Medical Ventricul ar Minute: Examiner Examiner Myocar Dia physician and the burial-transit Sequentietly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as e consequence of) Cotonwo erojL a Physician/Medical Due to (or es a consequence of) 980 Part If. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Dfd tobacco use contribute to the cause of death? 12 Yee 2 No 3 Probably 4 Unknown Ligarette SMOKing signed b þ 24b. Wera autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed 2 No 1 Yes 1 ☐ Yes 2 ☐ No 8 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 200 No Other: 4 Nursing Home edical Certification: To 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 Other (Specify) 27. Manner of Death 28c. Injury et Work? 28d. Describe how injury occurred 28a. Dete of Injury (Month, Day Year) 28b. Time of 1 Netural 5 Pending investigation Euneral Director: Aftivities in by the fur-1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the Hosp within 24 hor To the Fune completely fi

Box 68760. Division of Vital Records, P.O. or Attending Physician:

this

After

Hospital

death v

Baitimore, Maryland 21215-0020

State Registrar

DHMH 16 Rev 6/95

(Check only one)

James

29b. Signature and title of certifier

4000 Mitz 31. Date filed (Month, Day, Year) 32. Registrar's Signature 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

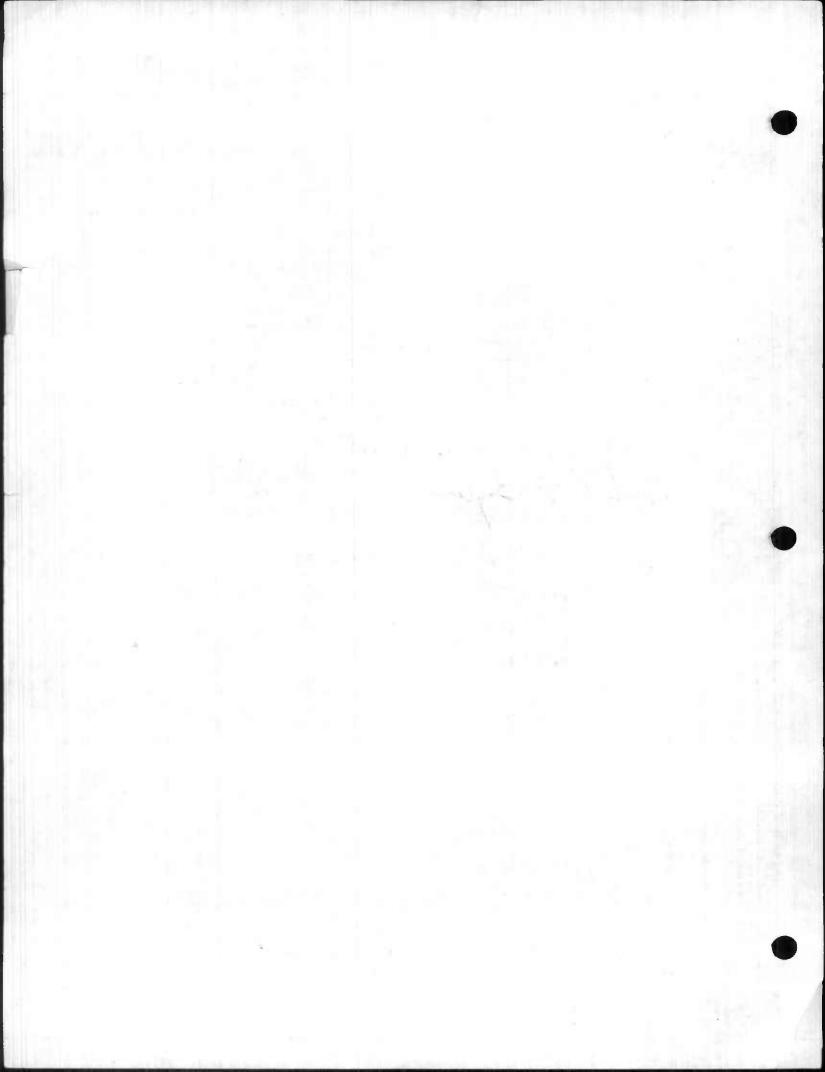
Tames W. Ross 4000 M. Hakella hellville

29c. License number

00023

29d. Date signed (Month, Dey, Year)

ORIGINAL



Please Type or Print in Black Indelibie Ink. Assure Ali Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death January 26 4000 William J. Beirne 2100 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Harford Fallston General Hospital Fallston If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours Months UMM 20 F 82 Yrs. 186-07-2400 July 9. 1917 Wayne, PA Usuai Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Bel Air Harford Maryland 15€Yes 2 No 10e Street and Number 10f. Zin Code 10g. Citizen of What Country? USA 21014 317 E. Belcrest 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) Customer Service Rep. Road Machinery, Inc 8th 17 Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Sumame) McGuigan Mary William Beirne 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 317 E. Belcrest Rd. Bel Air, Maryland 21014 Margaret Ann Heller/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Buriai 2 Cremation 3 Removal from State 1/29/00 W. Conshohocken, PA Calvary Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice 22. Name and Address of Facility
David J. Weber Funeral Homes, P.A.
401 S. Chester St. Baltimore, Maryland 21231 23a. Part1. Enter the disease, or emplications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of). Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Due to (or as a consequence of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably Toknown Filmellatio 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospitel: Inpatient 1 Yes 2 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred 27. Menner of Death 28e. Dete of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 1 Natural 5 Pending investigation 1 Tyes 2 No 2 Accident 6 Could not be 3 Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Division of Vital To the Hospital or within 24 hours after of To the Funeral Direct

Box 68760

Director:

Physician

/Medical

Examiner

Funeral

Director

28a-f show must be notified at

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"natural", or

Hygiene. Hygiene. Other than "n

permit. Pages 1 and 2 abouid be filled wit Department of Health and Mental Hygen. Important: If them 27 his marked other that any Injury or other treumatic event the

Physician

/Medical Examiner

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Physician/Medical

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Completed

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Certification:

Medical

Baltimore, Maryland 21215-0020

Director

Funeral

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Completed

Be

State Registrar

DHMH 16 Ray 6/95

31. Date filed (Month, Day, Year) JAN

29b. Signature and title of certifier

(Check only one)

Way le 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ORIGINAL

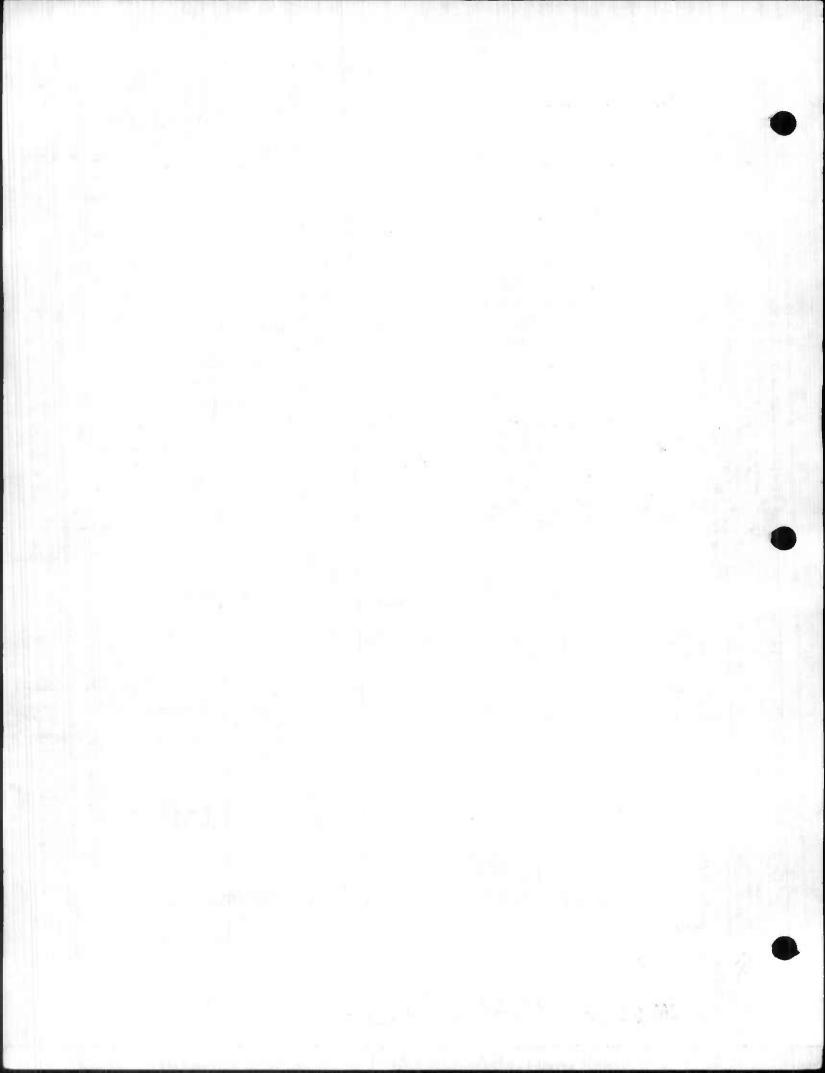
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

lyewood, MD 21040

29d. Date signed (Month, Day, Year)

01-28-00



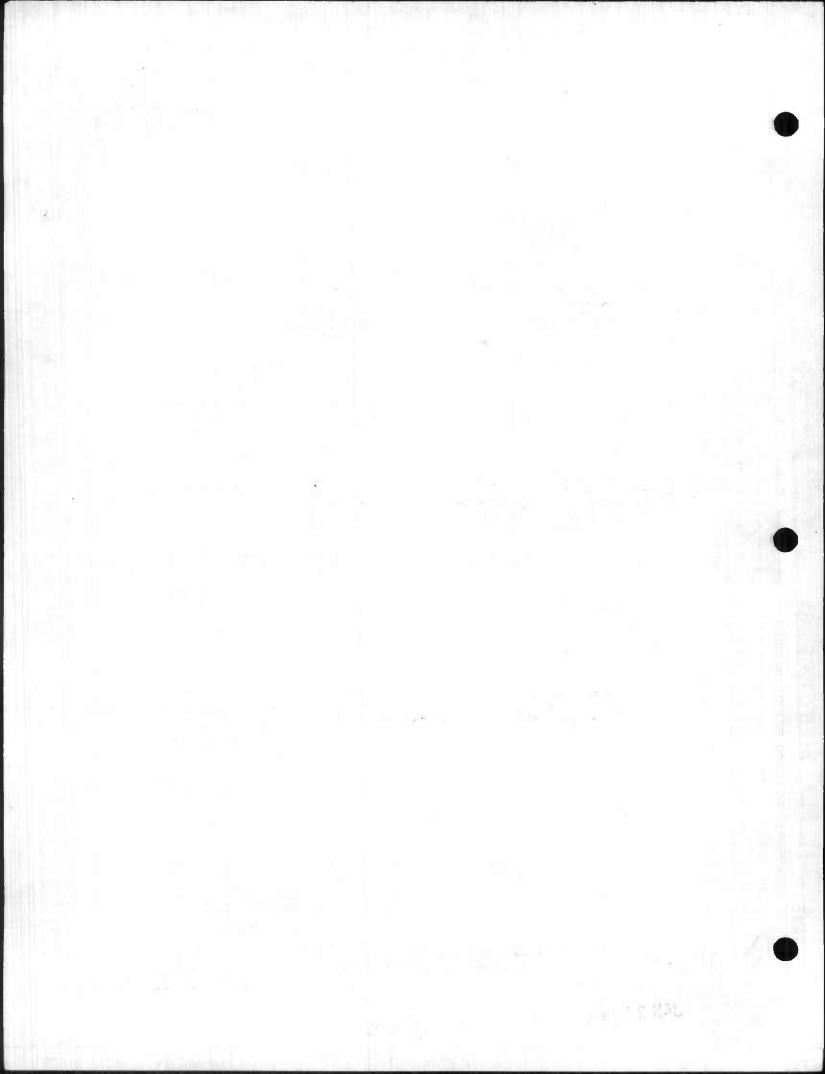
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician Dorothy May Bowen 12:25 JANUARY 26,2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Saint Agnes Hospital H Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, Year) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 200 F Months Days 235-50-3752 64 11/7/1935 West Virginia Director Usual Residence of Decedent 10a. State 10b. County 10c City Town or Location 10d. Inside City Limits Maryland Baltimore Catonsville 1 Yas 2 No Directo 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be r 107 C Belle Grove Road 21228 USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, atc. filed within 72 hours after 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 ò 1 Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Office Manager Health Care 12th 18. Mother's Name (First, Middle, Meiden Surname) 17. Father's Neme (First, Middle, Last) Pages 1 and 2 should be f hant of Health and Mantal ? int: if Item 27 is marked of Winnie Groove Ward Scott May 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Steta, Zip Code) 123 Foley Drive Garner, North Carolina 27529 Michael Bowen / Son 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Stete permit. Page Department d Important: If any injury or ance. 4 ☐ Donation 5 ☐ Other (Specify) 1/29/00 Baltimore, Maryland Greenmount Crematorium sture of Funeral Service Light 22. Name end Address of Fecility David J. Weber Funeral Homes, P.A. 23a. Pert1. Enter the disease of complications that ceused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximate Approximate Interval Between Onset and Deeth **Physician** Immediate Causa (Final disease or condition resulting In death) /Medical . hypertensive CARDIOVASCULAR dISEASE Examine Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury thet initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Due to (or as a consequence of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23h. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown ADENOCARCINOMA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? 1 Th Yes 18 Yes 2 No 2 No 25. Wes case referred to medical examiner? 88 26. Place of Deeth (Check only one) To Hospitel: 1 ☐ Inpatient 2 DER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? Certification: Division 5 Pending investigation 1 Yes 2 No 2 Accident after death Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide à 24 hours 112 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner stated. edicai (Check only one) Within 2 å 29b. Signature and tille of control 29d. Date signed (Month, Day, Year) 29c. License number ATTENDING D0054343 Name end address of person who completed cause of death (Item 23a) Prop. You C(A) HANSEN, M.D. STAGNES HEALTHCARE, BALTIMORE, MD. 32. Registra's Signature HRISTIAN H.

DHMH 16 Ray 6/95

State Registrar 31. Date filed (Month, Day, Year) JAN 3 1 2000

DOROTHY

ours



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** Eula Maybelle Barnes Month Vosr 2000 4:40 pm 28 January /Medical 4e. Fecility Neme (ff not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner n/a of Baltimore Hospital Baltimore If Under 1 Year If Under 24 Hrs. 6. Dete of Birth (Month, Dey, Year) May 2, 1933 7. Age (fn yrs. lest birthdey) **Funeral** Birthplace (State or Foreign Country) 1 M 2XX Yrs. Director **Uauel Residence of Decedent** the Maryland 10a Stete 10b. County 10c. City, Town or Location 7 is marked other than "natural", or frems 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 10d. Inside City Limits Md. n/a Baltimore 1 Yes 2 No Director 10e. Street and Number 3913 Annellen Road 10f. Zip Code 10g. Citizen of What Country? 21215 USA Funeral death 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Reca - American Indian, Bleck, White, etc. 11. Meritel Stetus hours after 1 ☐ Yes 2 ☐ Ne If Yes, Give Yeer or Dates: 1 ☐ Never Merried 2 ☐ Merried 1 Yes 2QNo Specify: specify: Black 2 3€Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) pernit. Pages 1 and 2 should be filed within 72 h
Department of Health and Mentai Hygiene.
Important: if fern 27 is marked other than "natu
any injury or other traumatic event, trailed one. 16b. Kind of Business/Industry Elementery/Secondary (0-12) Coilege (1-4or 5+) School Cafeteria Worker Baltimore City 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumame) Be Oscar Dickerson Vallie L. Peacock 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Williams daughter 3911 Annellen Road Baltimore, Md. 21215 20b. Piece of Disposition (Name of cemetery, cremetory or other piace)
Arbutus Memorial Park 20e. Method of Disposition 20c. Location - City or Town, State 11 Buriei 2 Cremetion 3 Removel from Stete Feb. 4 Baltimore, Md. 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility Nutter Funeral Homes, 21. Signeture of Funerel Service Licenses 2501 Gwynns Falls PKWY Baltimore, Md. 21216 6 relle 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Deeth **Physician** Immediate Cauae (Finel disease or condition resulting in death) /Medical Hemorrhagic Cerebrovasculer Accident Examiner Examiner Hypertension The law requires that the death certificate be executed physician and Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in deeth) Last Due to (or as e consequence of): Physician/Medical Due to (or es e consequence of): attending p 60 Pert it. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert t. 23b. Did tobacco use contribute to the cause of death? signed by (detach 1 Yaa 2 TNo 3 Probably 4 Unknown þ been sig Completed 24b. Were sutopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 2 s has 1 □ Yes 200 certificate 1 Yes Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica itely filled in by the funeral director, p Be 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Manner of Deeth 17 Matural 2 ☐ Accident 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? 5 Pending Investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ SuicIde 28e. Plece of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 4 ☐ Homicide To the Hospital within 24 hours a vithin 24 hours or To the Funeral Completely filled 29e. Cartifier 1x Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end pleca, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the best of examinetion end/or investigetion, in my opinion, deeth occurred at the time, dete end plece, and due to the cause(s) end menner stated. Medical 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year)

D0055609

2401 West Belvedere Avenue, Beltimore,

28,2000

21215

State Registrar 30. Name end address of person who completed cause of deeth (item 23a) (Type, Print)

32 Registrer's Signeture

hnistopher

31. Date filed (Montt

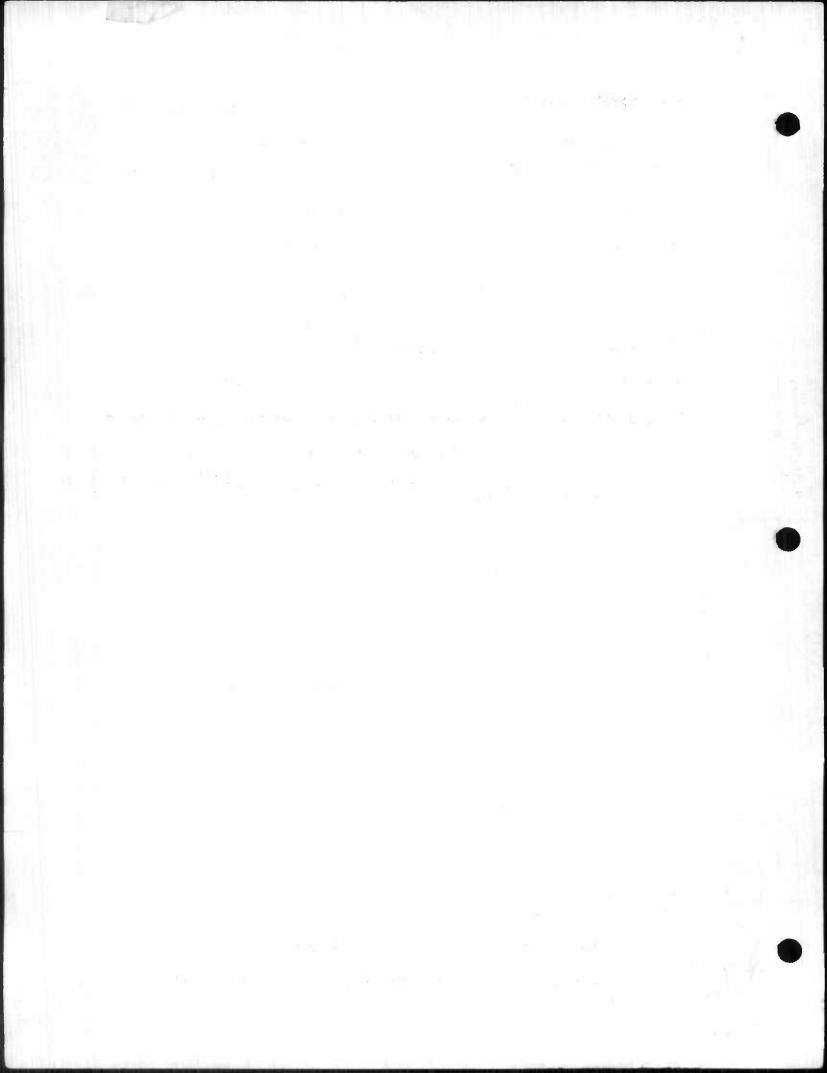
altimore, Maryland 21215-0020

P.O. Box 68760,

Records,

Division of Vital

laybelle Barnes



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Date of Death **Physician** Month 00 AN 11an 2000 JAN 28 /Medical 4a. Facility Name (If not institution, giva straat and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Silver Silver Spring WASHINGTON Ave Printy

8. Date of Birth
(Month, Day, Year)

13, 1916 Montgomery (In yrs. last birthday) 83 Yrs. 5. Social Security Number 6. Sex 1 M 2 ☐ F if Undar 1 Year 9. Birthplace (Stata or Foraign **Funeral** Montha Days Hours 579-32-7486 Usual Residence of Decedent Director CANADA 10a State 10b. County 10c. City, Town or Location 10d. Inaide City Limits ns 23a or 28a-f show Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? WASHINGTON 20 SA Completed by Funeral . Was Decedent Ever in U,S Armed Forcas? 1 Yes 20 No if Yes, Give Yaar or Dates: 7 is marked other than "natural", or items traumatic evant, the Wed cal Examiner ma 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puerto Ricen, atc.) 14. Race - Americen Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent'a Education (Spacify only highast grada complated) 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use ratired) 16b. Kind of Business/Industry Peges 1 and 2 should be filed within nent of Heelth and Mental Hygiene. Int: If flem 27 is marked other than Irry or other traumatic evant, the Me Elementary/Secondary (0-12) College (1-4or 5+) Chemical 17. Father's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Maldan Sumama) Rever Michae 19a. Informent's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rurel Routa Numbar, City or Town, Stata, Zip Coda) Mollie Berch Silver Spring MD 20910

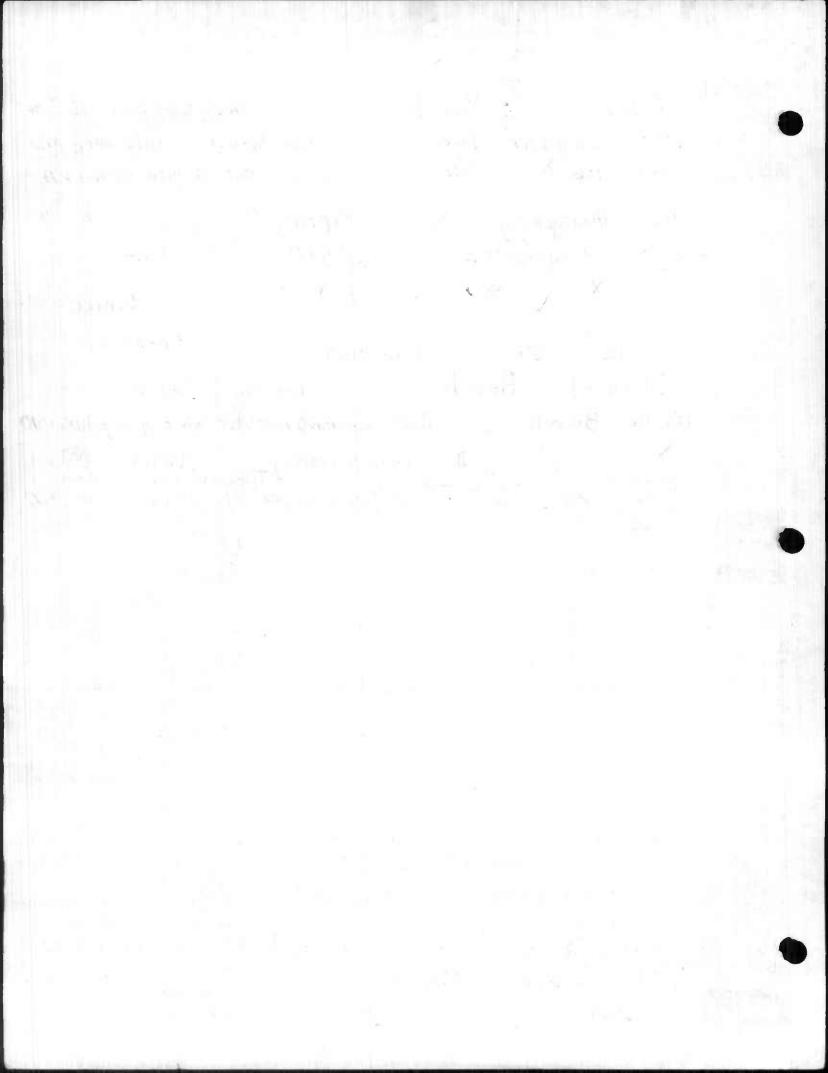
20c. Location City or Fewn, State 2100 Ave, WASHINGTON 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cematary, cramatory or other place) Date Burial 2 Cremation 3 Removal from State Depertment of Important: If any injury or Quhek (Specify LEBADON Cemetary 22. Name and Address of Facility_ Home Part1. Enter I diseasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or min failure. List only one cause on each line. DC 200 Approximete Interval Between Onset and Death Physician /Medical Immediate Causa (Final Pulmonary disaase or condition rasulting in death) hours Examiner Examiner pertensive Heart Disease The law requires that the death cartificate be executed Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Diseese or trijury that initiated events resulting in death) Lest Due to (or as e consequence of) Division of Vital Records, P.O. Box 68760. been signed by the ettending physician should be detached for use es the buria Physician/Medical Due to (or as a consequence of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 XNo 3 Probably 4 Unknown para paresis Be Completed by 24b. Ware autopsy findings evelleble prior to completion of cause of death? 24a. Was an autopsy performed? Sacral decubit this certificate hes dementia 1 Yes 2 No 1 Yes 2 No or Attanding Physician: 25. Was cese referred to medical examiner? 28. Place of Death (Check only ona) Certification: To Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatiant 2 ER/Outpatient 3 DOA 27. Manner of Deeth 28e. Date of tnjury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending Investigation 1 Watural . To the Hospital or Attendiff within 24 hours after death. To the Funeral Director: A completely filled in by the fi death. 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical 29a, Certifier 1 Certifying Phyelcian: To the best of my knowledge, deeth occurred at the time, date and place, and due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(a) and manner stated. (Check only one) 29b. Signature and titla of certifie 29c. Licanse number 29d. Date signed (Month, Day, Year) Mame and address of person who completed ceuse of death (Item 23a) (Type, Print) M.D. 8700 Georgia Ave #400 Silver Spring MD Kevess-

State Registrar 31. Date filed (Month, Day, Year)

JAN 3 1 2000

32. Registrar's Signature



He brew Home of Greater Washington Gld1 Mantrose Road Rockilleto

State Registrar TAMY B. Wilks, mg

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32 Begistrer's Signature

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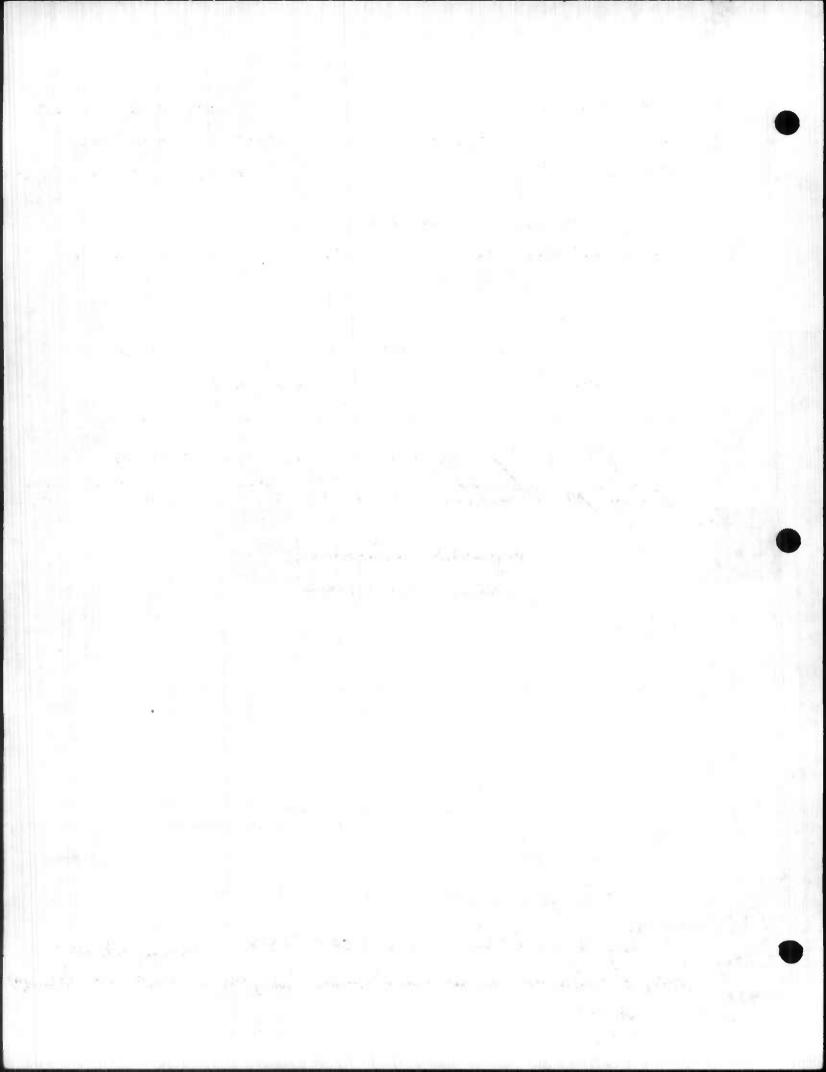
21215-0020

Baltimore, Maryland

Records, P.O. Box 68760.

of Vital

Division



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State of Maryland / Department of Health and Mental Hygien 0 2 1 5 2

| !-! | | | | | 001 | unou | IC OI | Death | | | Reg. No. | | | |
|--|--|--|--|--|--|--|---|------------------------------------|--------------------------------------|--|--|--|---|--|
| | 1. Decedent's Name (First, Middle, Last) GERALDINE BROWN | | | | | | | 2. Date of De | ath Day | Year | | ne of Death | | |
| ician dical | 46 | RALDIN | IE | 15 12 | -0W~ | | | | | JANUAL | 27 27 | 2000 | 00 | 830 AM |
| ner | NORTHWEST GOSPITAL MANDAUSTOWN MANYLAN | | | | | | | | | | | | | |
| 7 | 5. Social Security 212-09- Usuel Residence | 1 | ex 7 □M 2√2 F | Age (In yrs. | last birthday) Yrs. | Months | | Hours | | 8. Dete of Birt (Month, Da Nov. | 26 19] | 9. Birth Coul | olace (St ntry) MD | ate or Foreign |
| tor | 10a. Stete MD 10b. County BALTIMORE 10c. City, Town or Location BALTIMORE | | | | | | | | | | | de City Limits Yes 2 No | | |
| il Director | 10e. Street and N 6109 T | Umber CALLES RO | DAD | | | | ip Code 2120 | 7 | | | 10g. Citizen of What Country? | | | |
| by Funeral | | rried 2 Married | 12. Wes Decede Armed Force 1 Yes 2 If Yes, Give Year or Date | s? ③ No | | f Yes, sp | ecity Cubi | dispanic Origan, Mexican | gin? (Spe i, Puerto F | cify Yes or No Rican, etc.) | | aca - Americack, White, | | n, |
| Completed | (Spe | 15. Decedent's Ed | lucation de completed) College (1-40 | empleted) (| | Decedent's Usual Occupation Give kind of work done during most of work life. DO NOT use retired) | | | t of workin | 16b. Kind of Business/Industry | | dustry | | |
| | 12t | h (First, Middle, Last) | NA CLERICAL | | | AL W | | | (Eirot Middle | DRUGSTORE | | | | |
| o Be | | ROBERT W | | | | | | | | THOMPS | | iney | | |
| - | | Name/Retationship (7 WRIGHT - | * | 1 | | | | and Numbe | | BALTO | er, City or Tow | | 229 | |
| | 4.6 | isposition Cremetion 3 Compared to 1 Compared to 2 Compared to 3 Compared to 3 Compared to 4 Comp | | | Place of Dispo cemetery, crem RISON | matani ar | other play | ce) ETERAN | IS 2/ | Date 4/00 | 20c. Location OWINGS | | | • ARYLANI |
| n al | 23a. Perti. Enter shock, or he Immediate Cause | r the disease, or comp eart failure. List only | | | th. Do not ent | er the mo | ode of dyir | ASH A | cardiac or | BAL 7 respiratory ar | rrest, | D 2 | Approx Interva Onset | |
| Medical Examiner | disease or condit- resulting in death Sequentially list of any, leading to cause. Enter Unc Cause (Disease at that initiated even resulting in death) | conditions, immediate derlying or injury | a. R | Due to (| or as a consequence or a con | uence of (M 0, uence of |): NIA): | | IPE | Ē | | | | |
| Medical Examiner | disease or condit resulting in death Sequentially list of any, leading to cause. Enter Uncause (Disease othat initiated even resulting in death) | conditions, immediate derlying or injury | b | Due to (d | PNEU or es a consequence as a consequenc | uence of (M 0./ uence of) |): NIA): | | IR | 23b. Did | tobacco use c | | | - |
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Tima of Death Month **Physician** Tanuary 22 2000 GERTRUDE D. BROWN · /Medical 4c. County of Deeth 4b, City, Town, or Location of Deeth 4e Fecility Neme (If not institution, give street end number) Examiner aryland reneral If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Sociel Security Number 7. Age (In yrs. lest birthdey) 9. Birthplece (State or Foreign **Funeral** Deys Min. 1 M ACKE 87 Yrs MAR 28 1912 Director 266-40-8233 NEW YORK Usuel Residence of Decedent 10e Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits XXYes 2 □ No Director BALTIMORE CITY MARYLAND N/A 10e. Street and Number 10f. Zlp Code 10g. Citizen of What Country? 8 traumatic event, the Medical Examiner must be Herma 23a 1501 N DUKELAND STREET Funeral 21216 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Race - American Indien. Bleck, White, etc. 1 Yes 2 No If Yes, Give Year or Detes: 1 Never Married 2 Merried 8 1 Yes 2 XNo Specify: Specify: BLACK þ 3 ₩idowed 4 Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. College (1-4or 5+) Elementery/Secondery (0-12) HOUSEWIFE DOMESTIC 12th 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Melden Sumeme) h and Mental / should be SPENCER DAVIS MARY ROSS DAVIS 0 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 1 and 2 Department of Health important: If Item 27 Rose M. Nunn/Daughter 557 Brunswick Dr., Vallejo, CA. 94591 Saltimore, 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition Dete Pages 1 Description 2 Cremetion 3 Removel from State 4 Donation 5 Other (Specify) 8 1-31-00 OWINGS MILLS, MARYLAND GARRISON FOREST 21. Signature of Funeral Segrica Libensee 22. Name end Address of Fecility WILLIAM C BROWN COMMUNITY FUNERAL HOME PA 1206 W NORTH AVENUE Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart ailure. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** /Medical Immediate Ceuse (Final diseese or condition resulting in death) Examiner Examiner physician and s tha burial-transit certificate be axecuted Sequentielly list conditions, if any, leading to Immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Lest Due to (or es a consequence of) Physician/Medical Due to (or es a consequence of) nse ed by the a Pert il. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contributa to the cause of death? P.O. 1 Yes 2 No 3 Probably 4 D Unknown signed be de Records, by 24b. Were autopsy findings available prior to Completed 24e. Wes en eutopsy been completion of cause of death? 1 Yes 2 ₽ No certificate 1 ☐ Yes 2 ☐ No Division of Vital Be 25. Wes cese referred to medical exeminer? 26. Piece of Deeth (Check only one) Hospitel: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 2 ER/Outpatient 3 DOA 28e. Dete of Injury (Month, Day Year) funeral 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Attending 1 Neturel 5 Pending death. 1 ☐ Yes 2 ☐ No Investigation 2 Accident or Attend after death Director: / 6 Could not be determined To the Hospital or Atter-within 24 hours after ded To the Funeral Director completely filled in by the 3 Suicide 281. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 12 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end manner es stated. 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, dete end piace, end due to the cause(s) end menner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signeture end title of certifier 29c. License number 30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

JAN 3 1 2000

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31. Dete filed (Month, Day, Year)

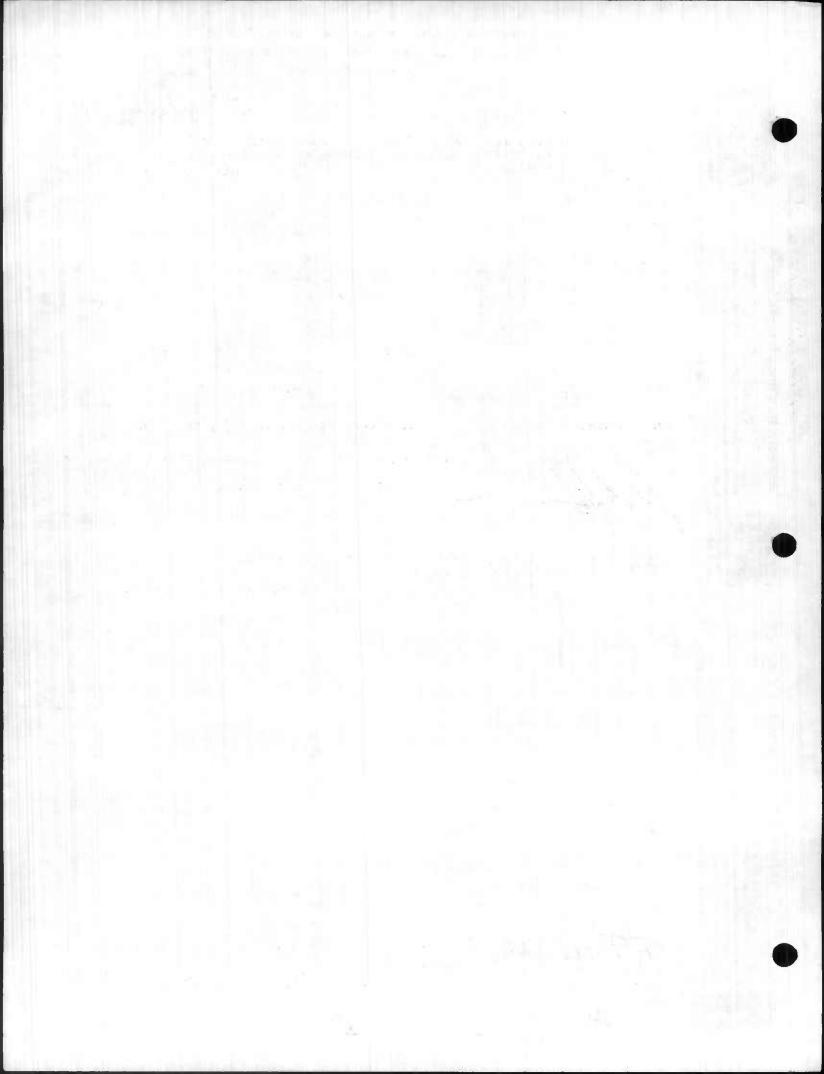
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32. Registrer's Signeture

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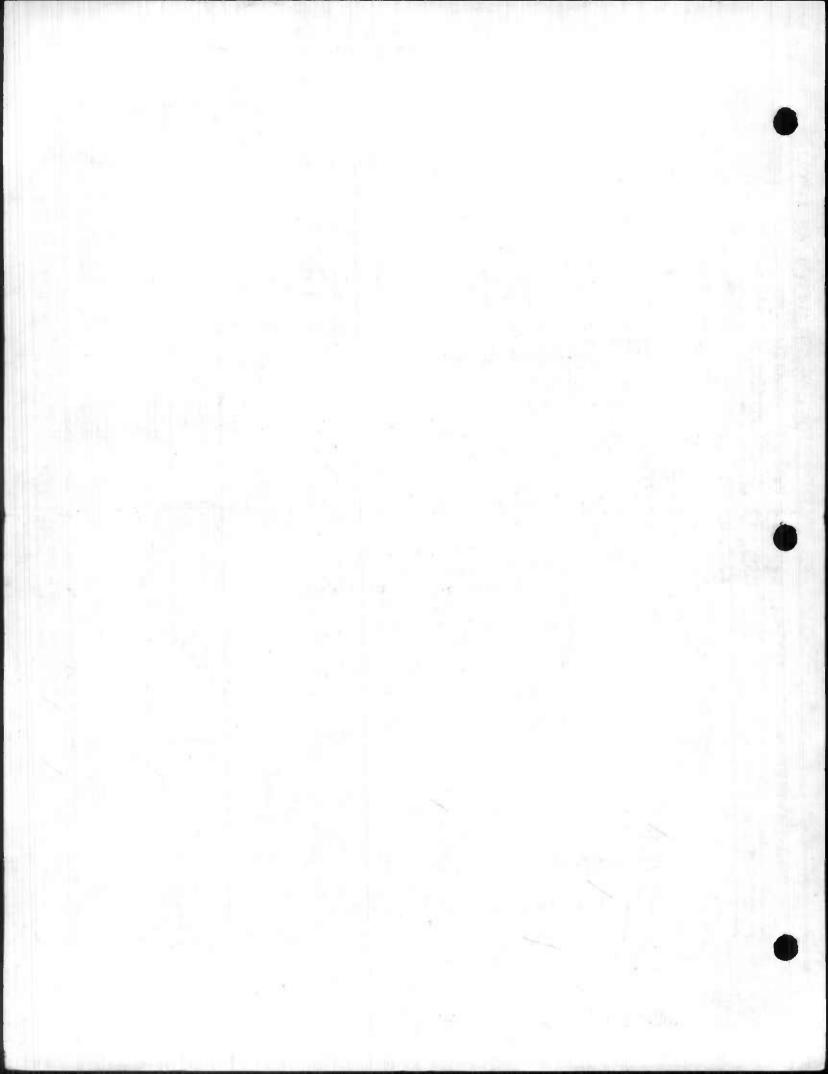
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|---|--|---|--|--|---|--|-----------------------------------|--------------------------|--|
| Physician | Decedent's Neme (First, Middle, La HELEN | V. BENT | | | | 2. Date of De Month | ath Day | Year 2000 | 3. Time of Death |
| /Medical Examiner | 4a Facility Name (If not institution, give SINAI HOSP): | re street and number) | BAZTIN | rolt | 4b. City, Town, o | or Location of Death | | | 11. 10 4 |
| Funeral Director | 5. Social Security Number 6. S Unknown Usual Residence of Decedent | Sex 7. Aga (fin 1□ M 2只 F 87 | yrs. last birthday, Yrs. | Months Dey | | | y, Year) | 9. Birthp Coun | elace (Stete or Foreign etry) LAND |
| or zae-t show be notified at Director | 10a. State 10b. County MARYLAND N/ | | | 1 | Od. Inside City Limits | | | | |
| ust be notified ust be notified al Director | 10e. Street and Number 3912 DORCHEST | ER ROAD | | 10f. Zip Code | 21207 | | 10g. Citizen of | What Coun | ntry? |
| by Funera | 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. Wes Decedent Ever Armed Forces? 1 Yes 2 No If Yes, Give X Year or Dates: | in U,S. 13. | Wes Decedent of If Yes, specify Co | | (Specify Yes or No erto Rican, etc.) | - 14. Rad Bla | e - Americ ck, White, | |
| Completed | (Specify only highest gra Elementary/Secondary (0-12) | (Specify only highest grade completed) /Secondary (0-12) College (1-4or 5+) | | | Usuel Occupation of work done during most of working Of use retired) NSURANCE EXAMINER SOCIAL SE | | | | |
| To Be | 17. Father's Name (First, Middle, Last) | | | | | lame (First, Middle, Know | | ne) | |
| ny injury or other tra nos. | COMP . WILLIAM DO 20a. Method of Disposition 15 Burial 2 Cremation 3 C 4 Donation 5 Other (Specification 2) 21. Signature of Funeral Service Licer | Removel from Stete | Ob. Plece of Disposers, cre ARBUTUS | MEM_P | ARK JA | E LANE Date N29,200 GS FUNE | 20c. Location | O, MD | own, Stata |
| sician edical | 23a. Pert1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) | | WAR | 412 E. | DRECTO | M Cm D | AT MO M | D. | 21213 Approximate Intervel Between Onset and Deeth |
| ysician and he burlat-transit Ical Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. CLOSTRI Due | to (or as a conse ND) U M to (or es a conse EU M ON to (or as a consec | DIFFI quence of): | CILE D | IARPHEA | | | DAYS DAYS |
| Phys | Part II. Other significant conditions of | contributing to death but no | ot resulting in the u | inderlying cause | given in Part I. | | tobacco use co | ntribute to | the cause of death? |
| shou | | | | | | 24a. Was | an autopsy med? | av. | ere autopsy tindings ailable prior to impletion of cause death? |
| Be Comp | 25. Was case referred to medical | | | | 26. Place of C | 1 🗆 v | | | Yes 20 No |
| y the funeral di | examiner? 1 Yes 2 No 27. Manns of Death 1 Naturat 2 Accident 3 Suicide 6 Could not be determined | e con Diana di laina | At homa, farm, st | M 1 | Other: 4 Nursing jury at Fork? Yes 2 No | Home 5 Resident Resid | dence 6 Ott | rred | y) si Route Number, |
| To the Funeral Dire completely filled in to Medical Certi | 29a. Certifier 1 Certifying Ph | nysician: To the best of my niner: On the basis of exa and manner steted. | y knowledge, deet mination and/or in | h occurred et the vestigetion, in m | time, date and pla y opinion, deeth oc | ce, and due to the curred et the time, | cause(s) and m date and place, | anner as s and due to | tated. o the cause(s) |
| M M | 29b. Signature and title of certifier | MP | | | onse number > 00534 | 05 | 29d. Date signe | N 211 | 1000 |
| State Registrar | 30. Name and address of person who have the way of the state of the st | 44.5 | AI HOSP/ Signeture | 0 | OI WEST | - BELVED | EREAVE | BAC | TIMOK, MD 21215 |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.



Please Type or Print in Black indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Nama (First, Middla, Last) 2. Date of Death **Physician** JANUARY 27 11:20 AM Lindon Uhle Cockroft /Medical 4a Facility Nama (If not Institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Doctors' Community Hospital Prince George's Lanham If Under 24 Hrs. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplace (Stata or Foreign Country) **Funeral** Days Months Hours 287 22 2260 71 July 10,1928 Cleveland OH Director Usual Rasidenca of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show show PQKYes 2 □ No Maryland Prince George's Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 12819 Belhurst Lane 20715 United States Nerna 23a 12. Was Decedent Ever in U.S. Armed Forces? ↑☆Yas 2 □ No If Yas, Giva Year or Datas: 52-54 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Raca - Amarican Indian, 11. Marital Status Black, Whita, atc. 1 ☐ Nevar Merried 2 ☐ Married "natural", or Specify: White 1 ☐ Yes 2 ☐ No Specify: ğ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highast grada completed) tal Hygiens. d other than "r Elementery/Secondary (0-12) College (1-4or 5+) Economist Federal Government 18. Mother's Name (First, Middla, Maiden Surname) 17. Father's Name (First, Middla, Last) Be Pages 1 and 2 should be nent of Health and Mental Important: If them 27 is marked, eny injury or other treumatic evinces. Arnold Cockroft Violet E. (Unavailable) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informent's Name/Ralationship (Type, Print) Linda Hughes Daughter 4763 Truman Hill Road Hardy Virginia 20b. Place of Disposition (Name of cametery, crematory or other place) Jan. 31, Dato 00 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cramation 3 ☐ Removal from Stata The Huntt Crematory Waldorf Maryland 4 Donation 5 Other (Specify) 22 Name and Address of Facility Robert E. Evans Funeral Home, Inc. a of Funeral 16000 Annapolis Rd. Bowie Maryland 20715 23a. Pert1. Enter the disease, or complications that callsed the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on ag h line. Approximete Interval Between Onset and Death **Physician** /Medical Immediata Ceuse (Finel disaasa or condition resulting In death) Day 20,000 Examiner Examine physician and s the burial-transit The law requires that the deeth certificate be executed Sequentially list conditions, if any, laading to immadiate causa. Enter Undarlying Cause (Disease or Injury that initieted events rasulting In death) Last Due to for as a cons Physician/Medical Due to (or as a consequence of): Pert II. Other significant conditions confributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 | Yea 2 | No 3 | Probably 4 | Unknown þ 24b. Wara autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: Be 25. Was casa referred to medical examiner? 26. Placa of Death (Check only ona) Hospital: 1 Schopation 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yas 2 ☑ No this funeral 27. Mannar of Death 28b. Tima of Injury 28d. Describe how injury occurred 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 1 Natural 5 Pending 24 hours after death. Investigation 1 Yes 2 No 2 Accidant 6 Could not be datamined 3 Suicide 28a. Place of Injury - At homa, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 HomicIda Hospital edical 29a. Certifier 1🖄 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. (Check only To the To the F 29b. Signeture and titla of pertifier 29c. License number 29d. Data signed (Month, Day, Year) 45660

State Registrar 30. Name and address of p

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Box 68760.

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Division of Vital Records,

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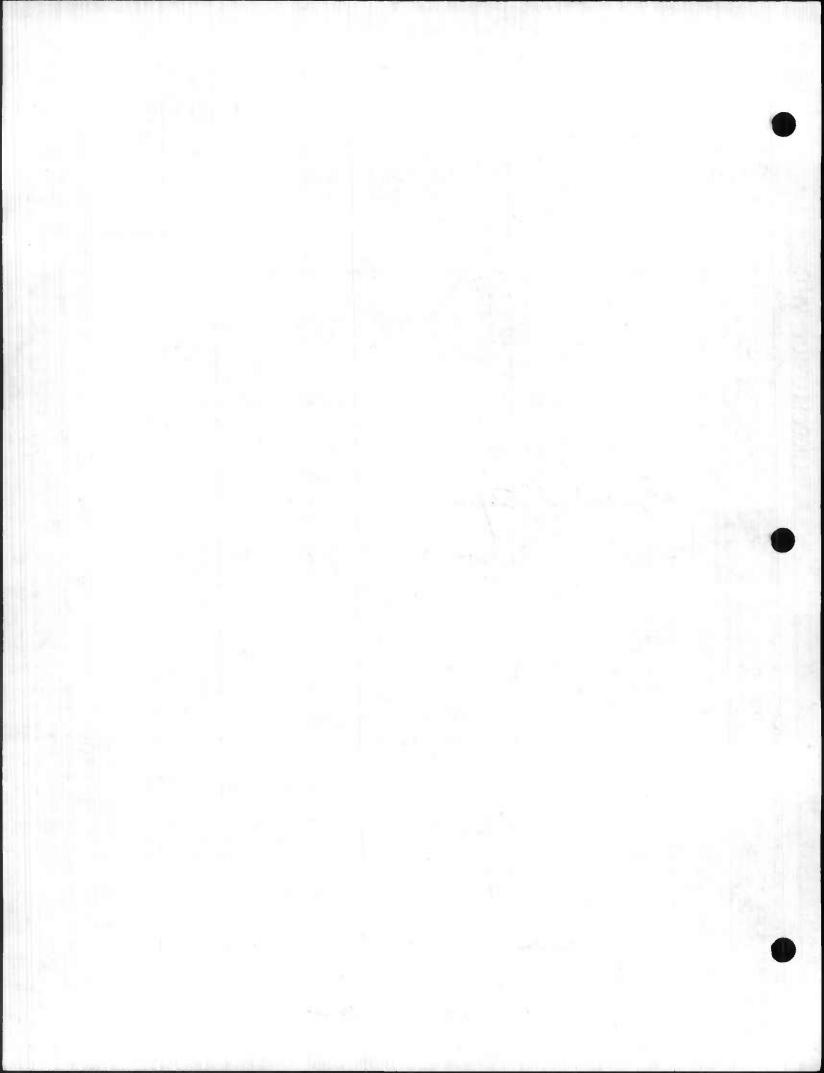
rson who completed causa of death (Item 23a) (Type, Print)

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32. Registrar's Signature

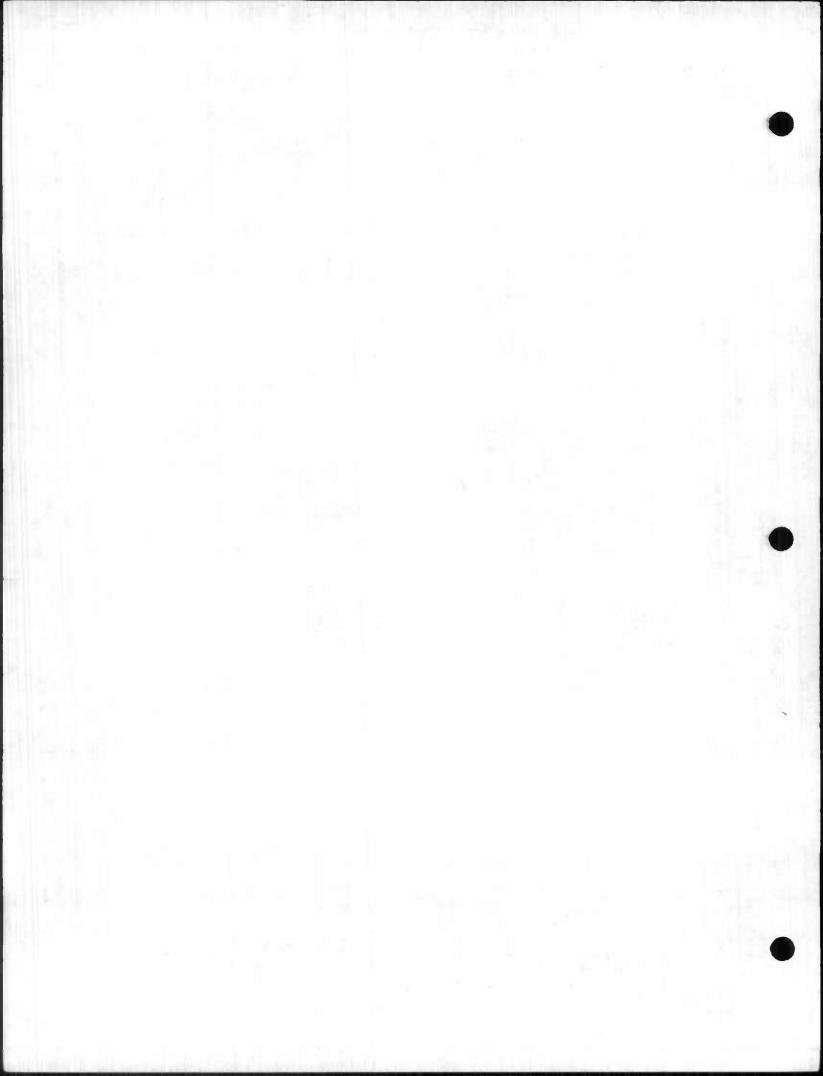
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| Amended | | Pepartment of Health and Me Certificate of Death | Reg. No. 02156 |
|--|--|---|---|
| Physician /Medica | May Disney Carre | | 2. Dafe of Death Month Day Year JANUARY 20 2000 10:25 P.M. |
| Examine Funeral Director | GREATER BALTIMORE MEDICAL CENTER 5. Social Security Number 6. Sex 1 M 2 K 7. Age (In yrs. last birt) | Months Days Hours Min. | BALTIMORE B. Deta of Birth (Month, Day, Year) Ctober 9, 1904 Maryland |
| ehow | Usual Residence of Decedent 10a. State 10b. County 10c. City, Town | | 10d. Inside City Limits |
| the Maryla 28e-f ehor | MD N/A Baltim | | 1 □Yes 2 □ No |
| with the or 2 | 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
| 11215-0020 within 72 hours after death with the Maryland ene. than "natural", or thems 23s or 28s-1 show his Wedesl Examiner maint be notified at | 6401 Loch Raven Blvd. 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 Who If Yes, Give Yeer or Detes: | 21239 13. Was Decedent of Hispanic Origin? (Speciff Yes, specify Cuban, Mexican, Puerto Ri | Black, White, etc. Specify: |
| ind 21215-00; be filed within 72 hours tal Hygiene. d other than "natural", avent, ma bedical Ex- | | Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | |
| nd 2 | 17. Fether's Neme (First, Middle, Last) | Secretary 18. Mother's Nama (| First, Middle, Maiden Sumame) |
| Aaryland 212 2 should be filed with and Mental Hygiene. Is marked other that reumatic event, the | Isadore Whitestone | Carrie La | 00 |
| Baltimore, Maryland : Dearmit. Pages 1 and 2 should be filed Department of Health and Mental Hys Important: if flem 27 is marked other any injury or other traumatic event, page. To Be C | | Mailing Address (Street and Number or Rural and Street and | |
| | 20a. Method of Disposition 1 (XBuriel 2 Cremation 3 Ramovel from Stete 20b. Place of cemetery | Disposition (Name of , crematory or other place) | Date 20c. Location - City or Town, State |
| | 4 Donation 5 Other (Specify) Loudon | Park 1/2 22. Name and Address of Facility | 26/2000 Catonsville, MD |
| | 1 Cayal | Ruck Towson Funeral Home | Inc. Touson MD 21204 |
| Physician /Medical Examiner | Immediate Cause (Final disease or complications that caused the death. Do not heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a condition as a conditi | ot entar tha mode of dying, such as cardiac or | respiratory arrest, Approximate Interval Between Onset and Death |
| is, P.O. Box 68760, es that the death certificate be executed igned by the attending physician and be detached for use as the burial-transit by Dhysician Madical Exemines | | onsequence of): | |
| the de lached | Part If. Other afgnificant conditions contributing to death but not resulting in | the underlying cause given in Part I. | 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown |
| ecord aw requir | | | 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? |
| f Vital Revision: The last continuate he director, page | | | 1 Yes 2 No 1 Yes 2 No |
| of VItahis cartiful director | | 26. Place of Death (| Check only one) a 5 ☐ Residence 6 ☐ Other (Specify) |
| Division of Vita To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director, Medical Certification: To Be of | | me of Jury at Work? M 1 Yes 2 No | ld. Describe how injury occurred |
| Division And State of And State of And State of | 3 ☐ Suicide 4 ☐ Homlcida 6 ☐ Could not be determined 28a. Place of Injury - At homa, fan building, atc. (Specify) | n, street, factory, office 28 | Location (Street and Number or Rural Route Number, City or Town, State) |
| Division To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funeral Medical Certification | 29a. Certifier (Check only one) 1 Certifying Physician: To tha best of my knowledge, 2 Medical Examiner: On the basis of examination and and mannar stated. | death occurred at the time, date and place, an /or investigation, in my opinion, death occurred | d due to the cause(s) and manner as stated. If at the time, data and place, and due to the cause(s) |
| To the common of | 29b. Signeture and title of certifier I Mould | 29c. License number D32 639 | 29d. Date signed (Month, Day, Year) Start 2200 |
| | 30. Name and address of person mo completed cause of goath (Item 23a) (Tomothy Herlihy 660 Keyiluzi | Type, Print) | |
| State Registrar | 31. Dete filed (Month, Day, Year) JAN 3 1 2000 32. Registrar's Signature | & Sporks | |



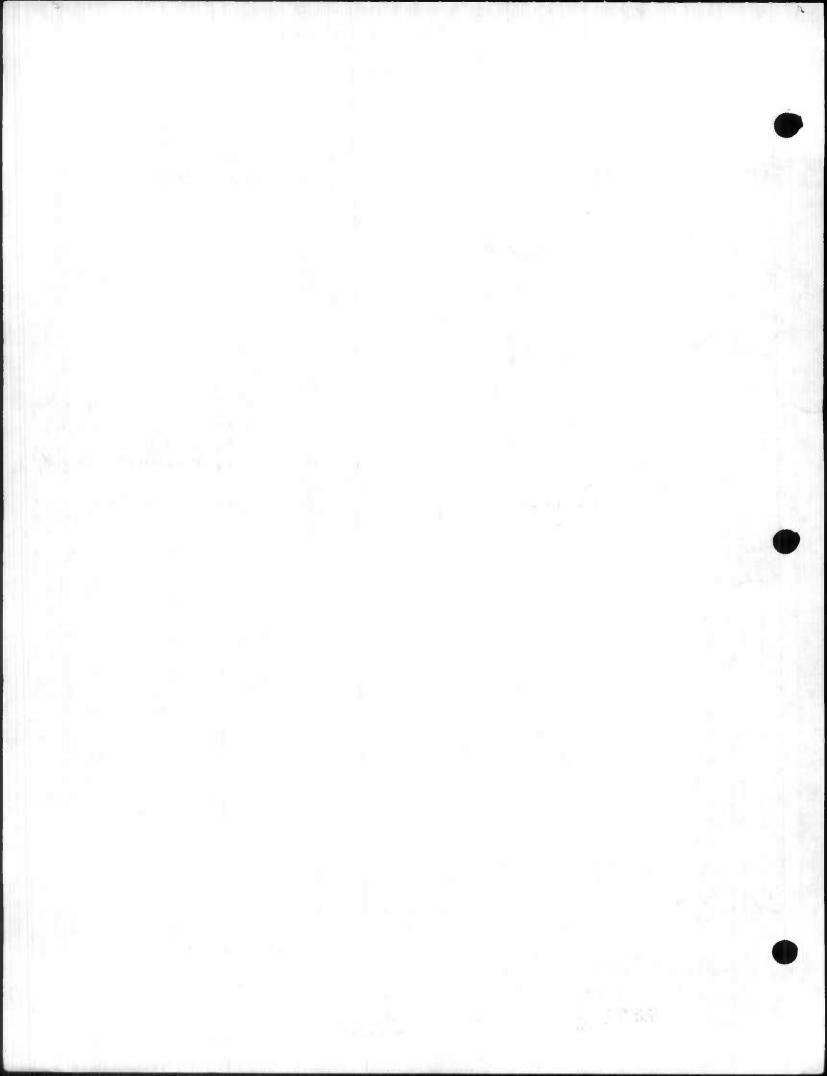
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 02157

| | Certificate of Death | Reg. No. | V to 1 V I | | |
|--|--|--|--|--|--|
| Physician /Medical | 1. Decedent's Neme (First, Middle, Last) Brenda Jean Carter | 2. Date of Death Month Dey 24 | Yeer 5:55 pm | | |
| Examiner | Johns Hopkins Hospital Balt | imore N | | | |
| Funeral Director | 5. Social Security Number 6. Sex 1 Moet 1 Year Hunder 1 Year Sex Hours 7. Age (In yrs. lest birthdey) Yrs. Usual Residence of Decedent | Min. 8. Dete of Birth (Month, Dey, Year) | 9. Birthplace (State or Foreign Country) | | |
| hall hygiene and manyand tall hygiene about with the manyand of other than "natural", or items 23s or 28s-f about event, the Medical Examiner must be notified at Be Completed by Funeral Director | 10a. Stete 10b. County 10c. City, Town or Location Md NA Baltinore | | 10d. Inside City Limits 1 Yes 2 □ No | | |
| r tiems 23s or 28s4 s near most be notified Funeral Director | 10e. Street and Number 621 N. Montford Ave 21205 | | What Country? | | |
| Example In | 11. Meritel Stetus 1 Never Merried 2 Merried 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, Sipe 1 No If Yes, Specify: 1 Yes, Sipe 2 No If Yes, Sipe 2 No If Yes, Specify: 1 Yes 2 No Specify: | in? (Specify Yas or No- Puerto Rican, etc.) 14. Re Bl | ice - American Indien, eck, White, etc. ity: Black | | |
| tal Hygiene. d other than "natural", of avent, me Medical Exal Be Completed by | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4or 5+) Bay Mad | of working 16b. Kind of l | Business/Industry | | |
| Copputation or return and water any important; if fem 27 is marked other than any injury or other traumatic avent, the Modes. To Be Compi | 17. Father's Name (First, Middle, Last) Clarence L. Carter, S. Auc | 's Name (First, Middle, Maiden Sume Lrey S. COOM | 65 | | |
| em 27 is ma other traum | 19e. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number 8 10 6 Milford) 20a. Method of Disposition 20b. Place of Disposition (Neme of | Garden Dr. | n, State, Zip Code) Z1244 Ba 140, MG 1- City or Town, State | | |
| tment o tant: If I | 1 Buriel 2 Cremetion 3 Removel from State 4 Donation 5 Other (Specify) Cemetery, cremetory or other place) KING Memoral Park | 2-2-2000 Rand | 1 12 | | |
| importing any in | March F. H. W. | out frence R | Rely, Md 2,215 | | |
| ysiclan Medical | 23e. 1.1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as complete, or heart feiture. List only one cause on each line. | | Intervel Between Onset and Deeth | | |
| aminer | Immediate Cause (Final diaease or condition resulting in death) a. Metastatic colon ca Due to (or as a consequenca of): | NCE | 3 79 | | |
| ms prysician and as the burial-transit | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury c. | | | | |
| | thet initieted events resulting in deeth) Last Due to (or es a consequence of): d. | | | | |
| of for | Part II Other standilland and literature and the second in | 22h Did tahagaa uus C | ontributa to the cause of death? | | |
| d by the estache | Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. | 1 Yas 2 No | | | |
| page 2 should be d | | 24a. Was en autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? | | |
| ector, page Betor, page | | 1 □ Yes 2 No | 1 ☐ Yas 2 ☐ No | | |
| certificate rector, pa | eveminer? | of Deeth (Check only one) | | | |
| John John John John John John John John | | 28d. Describe how injury occ | 5 Residenca 6 Other (Specify) Describe how injury occurred | | |
| in the | 3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) | 28f. Location (Street end Nur City or Town, Stete) | nber or Rural Route Number, | | |
| To the Fuheral Completely filled | 29e. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and manner steted. Certifying Physician: To the best of my knowledge, death occurred at the time, date and and manner steted. | d place, and due to the cause(s) and on his occurred at the time, date and place | manner as stated. e, and due to the cause(s) | | |
| Toth | 29b. Signeture end title of certifier 29c. License number | 1 | ned (Month, Dey, Year) | | |
| M | 30. Name and address of person who complete cause of deeth (Item 23a) (Type, Print) Michelle June 23 (315 N, Calvert St. Bo | | 07 | | |
| State | 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture | A 110. MO 212 | · - | | |
| Registrar | JAN 3 1 2000 Se Dece 4 | | | | |

DHMH 16 Rav 6/95

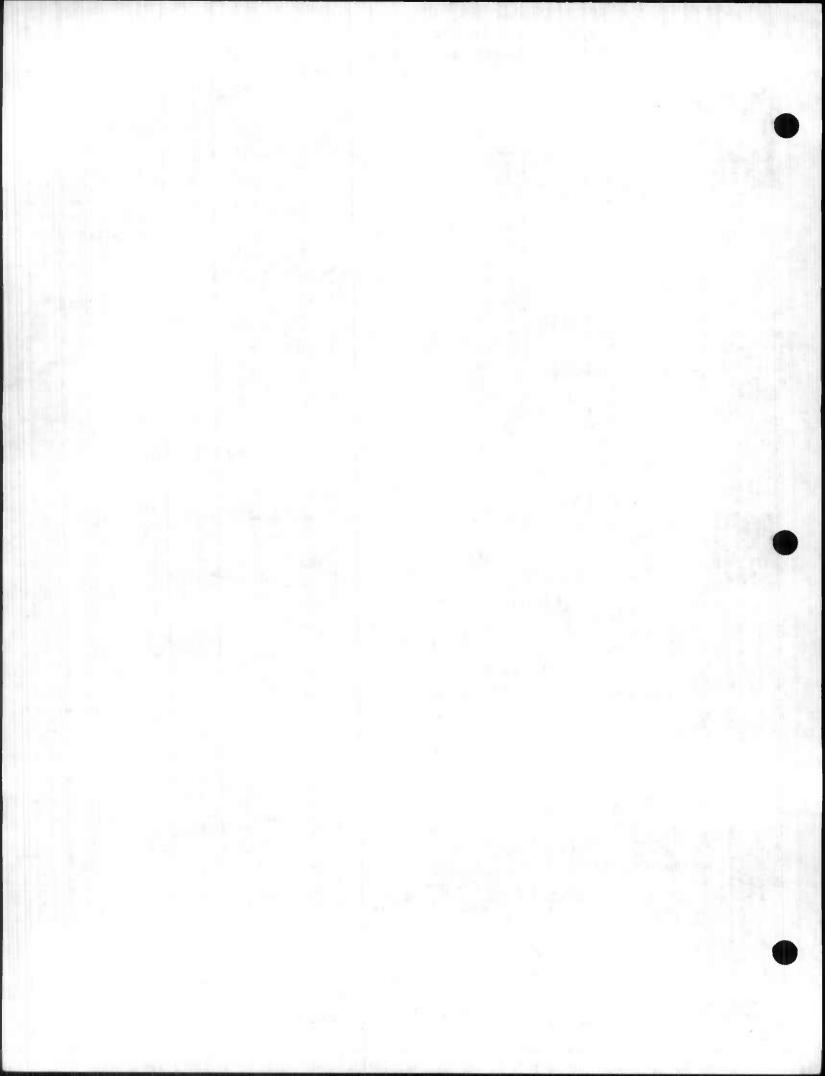
ORIGINAL



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| | | | | | 00 | |
|----------|------------|------------|-----------|------------|-----------|--|
| State of | Maryland / | Department | of Health | and Mental | Hygiene 0 | |
| 4 .1 1 | | | | | | |

| NIK. 00 02 | Steven Bernard Co | orbin | Certificate of Death | Reg | ı. No. | | | |
|--|--|--|--|--|--|--|--|--|
| Physician | Decedent's Name (First, Middle, Last) STEVEN B. COR | BIN | factor in the second | 2. Date of Death Month | Day Year | 3. Time of Death | | |
| /Medical Examiner | 4a Facility Name (If not Institution, give sta JOHN HOPKINS BAYV | | | Location of Death | | | | |
| • Funeral Director | 5. Social Security Number 6. Sex | 7. Age (In yrs. last bi | | | (ear) 9. Birthp | place (State or Foreign ntry) YLAND | | |
| Maryland f ahow led.at | Usual Residence of Decedent 10a. State 10b. County MD BALTIMORI | | 1 | 10d. Inside City Limits 1 ☐ Yas 2 ◯XNo | | | | |
| th with the Ma 23a or 28a-fa ast be notified al Director | 10e. Street and Number 3124 WALLFORD DR | IVE APT. E | 10f. Zip Code 21222 | 10g | Citizen of What Cour U.S. | ntry? .A. | | |
| urs after dea af, or flems Examiner in by Funer | 11. Meritel Stetus 12 Never Married 2 Married 3 Widowed 4 Divorced | 2. Was Decedent Ever in U,S. Armed Forces? 1 Yes 2 No if Yes, Give Year or Detes: | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1□ Yes 2▼No Specify: 14. Race - American Ind Black, White, etc. Specify: WHITE | | | | | |
| ed within 72 ho ygiens. er then 'naturn t, the Medical. Completed | 15. Decedent's Educa (Specify only highest grade of Elementary/Secondery (0-12) | | Decedent's Usual Occupation (Give kind of work done during most of wo life. DO NOT use retired) FOREMAN | orking 16 | b. Kind of Business/In- | | | |
| tental Hyginad sevent, I | 17. Father's Name (First, Middle, Last) EILEEN | | 18. Mother's Na | me (First, Middle, Ma PRBIN | iden Sumame) | | | |
| and 2 show with and N 127 is men or traumen | 19a. Informant's Name/Relationship (Type JOHN NOPPINGER-ATIV | | b. Mailing Address (Street and Number or Fi 210 N. CHARLES ST. F | | | | | |
| Pages 1. ment of Ha ant: If Nem ury or oth | 20a. Method of Disposition 1 Burlel 2 XCremetion 3 Rei 4 Donetion 5 Other (Specify) | movel from State camete | of Disposition (Neme of bry, crematory or other place) 1/28/ MORE—WASHINGTON CREM | 00 | LAUREL, MAR | | | |
| Departition Departition of the series of the | 21. Segregate of Funeral Service Licensee | Seanske | 22. Name end Address of Facility CHARLES S. ZEILER 6224 EASTERN AVENU | | C. MORE, MD 21 | 1224 | | |
| Physician /Medical Examiner | shock, heart failure. List only one Immediate Cause (Final disease or condition resulting in death) a. | Multipe | not enter the mode of dying, such as cardial and the s | | | Approximete Interval Between Onset and Death | | |
| rdificate be assected ng physician and s as the burial-transit Medical Examiner | Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last | | consequence of): | | | | | |
| that the death cered by the attendin detached for use | Part if. Other algorificant conditions contr | ibuting to death but not resulting | in the underlying cause given in Part I. | 23b. Dld tobe | Did tobacco usa contribute to the causa of death | | | |
| the section of the se | | | | | | bably 4 Trinknow | | |
| P 2 se | | | | 24a. Was an performe | ed? av | fere autopsy findings vailable prior to empletion of cause death? | | |
| ysician: The liss certificate he director, page | 25. Was case referred to medical examiner? | | 26. Plece of De | eath (Check only one) | 200 | ØYes 2□ No | | |
| or Attending Physitier death. Nrector: After this in by the funeral distribution: To | 27. Manner of Death 1 Natural 28. Accident 3 Suicide 4 Homicide 1 No 10 10 10 10 10 10 10 10 10 1 | 28a. Dete of Injury (Month, Day Year) 28b. | Time of Injury at Work? 2-30 A 1 Yas 251No arm, street, factory, offica | 28d. Describe how | et and Number or Run State) | 16131bn | | |
| Hospi 4 hour Funer tely fill | | cian: To the best of my knowledge | e, deeth occurred at the time, date and placed or investigation, in my opinion, death occurred to the control of the control o | e, and due to the cau | use(s) and manner as s | | | |
| To the comple | 29b. Signeture end title of certifier | 1/2 | 29c. License number OCME | | d. Dete signed (Month, ANUARY 20, | | | |
| M | 30. Name and address of person who com | | (Type, Print) 1 Penn Street, Balt | imore, Mar | yland 2120 | 1 | | |
| State Registrar | 31. Date filed (Month, Day, Year) JAN 3 1 2 | 32. Registrar's Signature | & Sports | | | | | |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month WVIS largaret January 25-2000 4b. City, Town, or Location of Death 4a Facility Name (ILAot institution, give street and number) 4c. County of Death 08 Maryland Baltmore Medical N/A Inversion Lenter If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Yeer 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 9. Birthplace (State or Foreign Country) Months Days 1□ M 2√F 258-72-8665 94 MAR. 6,1905 ATLANTA **Usual Residence of Decedent** 10b. County 10c. City, Town or Location 10d. Inside City Limits N/A BALTIMORE Ha Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10 E. LEE STREET APT.1009 21206-6016 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Bleck, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes XXNo Specify: Specify: WHITE 3 ₩idowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) LIBRARIAN ELEMENTARY SCHOOL 4 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) WALTER WILLIAM WHITINGTON, SR. DAISY GAAR 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PAUL DAVIS - SON 10 E. LEE STREET APT.1009 BALTIMORE, MD 21206 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) WEST VIEW ABBEY 3/200 ATLANTA, GEORGIA

22. Name end Address of Facility

CHARLES S. ZEILER & SON, INC.

6224 EASTERN AVENUE BALTIMORE, MD 21224

Approximate Intervel Between Onset end Deeth

hrs.

permit. Pages 1 and 2 should be filed within 72 hours effect. Department of Health and Mentel Hyglena. Important if them 27 ie marked other than "natural". A many injury or other traumatic averages.

Physician

/Medical

Examiner

10a. State

MD

Funeral

Director

Nerna 23a or 28a-f ahow lose must be notified at

Director

Funeral

É

Completed

the Maryland

WITH

deeth

Physician /Medical Examiner

Records, P.O. Box 68760.

of Vital

Division

Examiner physician and the burial-transit Physician/Medical attending pl

23a. Part L. Entry the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, ordinart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) rema Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of) Rena Frilme Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? oer Ratemia 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 10 1 Inpatient 2 DOA

The law requires that the deeth certificate be executed 1 Yes 2 No 3 Probably 4 Unknown à 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? page 2 s hes 1 Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: 8 Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation To the Hospital or Attanding within 24 hours after death. To the Funeral Director: After completely filled in by the fun 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, and due to the cause(s) and manner as stated. Medical 29a. Certifier

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

MICHAEL

21. Signaturi ful Funeral Service Licensee

29c. License number 29d. Date signed (Month, Day, Year)

25/00

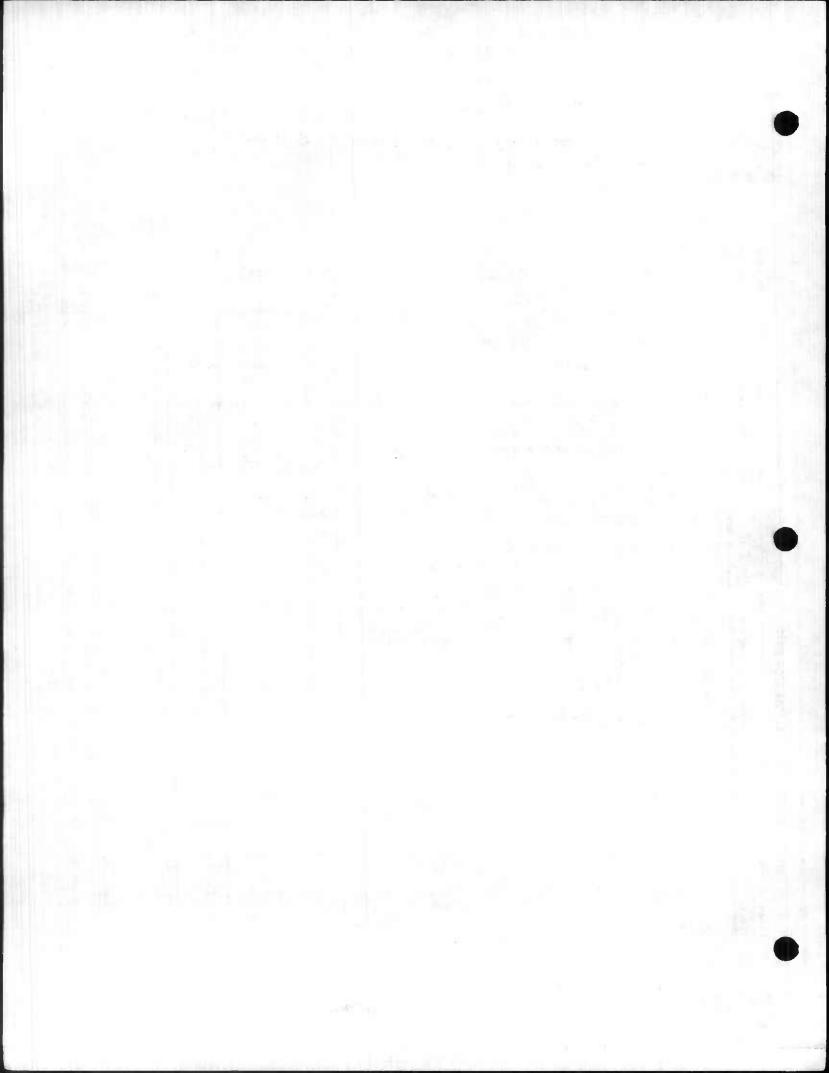
30. Name and address of person who completed gause of death (ttern 23a) (Type, Print)

UNIVERSITY OF MARYlan

State Registrar

31. Date filed (Month, Day, Year) JAN 3 1 2000

Kolnic 32. Registrar's Signature



Please Type or Print in Biack Indelible Ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death 28 2000 Month **Physician** 10:07pm January Frances Elizabeth Fields /Medical 4a Facility Neme (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cherrywood Future Care Reisterstown Baltimore 5. Sociei Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) July 17, 1917 Birthplace (State or Foreign Country) **Funeral** Days Hours 10 M 20XF Months 82 Director 214-18-5436 MD Usual Residence of Deceden 10a. State 10c. City, Town or Location 10b. County 10d. Inaide City Limits 1 ☐ Yes No Director Baltimore Reisterstown 280-1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ð the Medical Examiner must be 21136 632 St. Georges Station Road USA Nerne 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14 Race - American Indian 11. Maritel Stetus Bieck, White, atc. 1 Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Merried 8 1 Yes 2 No Specify: Specify: black à 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hypiene. College (1-4or 5+) Elementary/Secondery (0-12) permit. Pages 1 and 2 should be filed in Department of Health and Mental Hygien Important: If them 27 is marked other th any Injury or other two-Teacher Education 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be James Smith Nellie Cure 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21136 19a. Informant's Name/Relationship (Type, Print) Adrienne Karasik - daughter 632 St. Georges Station Rd., Reisterstown, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/1/2000 Beltsville, MD Chesapeake Crematory 22. Name and Address of Facility CAFA, Stephen D. Lohrmann, P.A. 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. 21286 Approximate Intervat Between Onset and Death **Physician** /Medical Immediata Cause (Final disease or condition resulting in deeth) 4months FAILURE TO Examiner Due to (or as a consequence of) 2 YEAMS PROGRESSIVE DEMENTIA Sequentially list conditiona, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and Physician/Medical Due to (or as a consequence of): Part It. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown VASCULAR OCCLUSIVE DISEASE py 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed Diabetes Mallitus Bleeding 1/x of Gastrointestinal 1 Yes 2 No 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Ves 2 No Hospital: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 28b. Time of 28c. Injury at Work? Affer or Attending 5 Pending 1 Tes 2 No death. 2 Accident after death Director: 3 ☐ Suicide 6 Could not be 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours aft To the Funeral Dis completely filled in Hospital 1 🗹 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end piece, and due to the cause(s) and manner stated. To the I 29d. Date signed (Month, Day, Year) 29b. Signeture end title of certifier 29c. License number 145931 January 31, 2000 Kerce lelierah -

DHMH 16 Ray 6/95

Baltimore, Maryland 21215-0020

Records, P.O. Box 68760,

Division of Vital

Registrar

31. Date filed (Month, Day, Year)

Deborah 2000 JAN31

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7220 32. Registrade Signeture PARK HEIGHTS AVE BALTO 21208

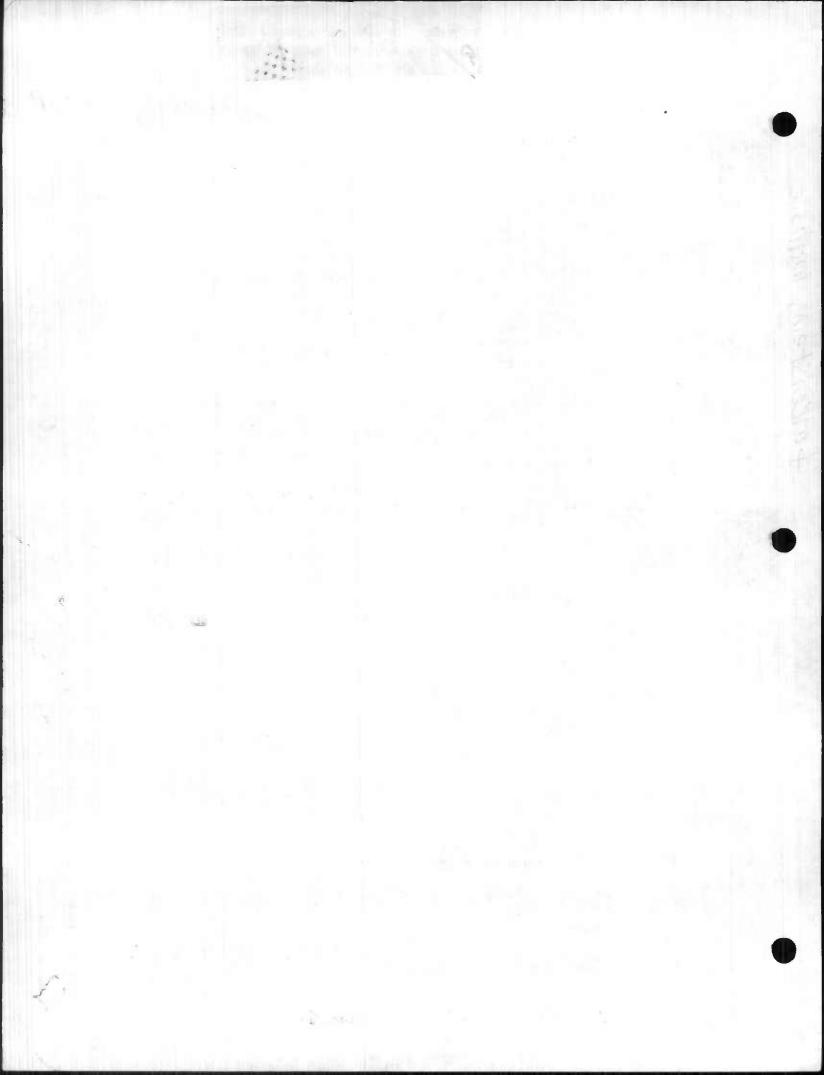


Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene O O

| | | Ota | io or mary | | ertificate of | Death | | leg. No. | 02161 | | | | |
|--|--|---|--|----------------------------------|--|---|--|------------------------------------|---|----------|--|--|--|
| | 1. Decedent's Neme (First, | Middle, Last) | | | | | 2. Date of Dea | th | 3. Time of D | eath | | | |
| Physician | WILLIAM | RICKI F | ALKENS | rein | | | JAN. 2 | 23, 2000 | ear 8:11 | P | | | |
| /Medical Examiner | 4a Fecility Neme (If not inst | itution, give street a | nd number) | | | 4b. City, Town, or L | | 4c. County of | | - | | | |
| | DULANEY 7 | OWSON H | EALTH (| CENTER | | TOWSON | | BALT | MORE | | | | |
| Funeral | 5. Social Security Number | 6. Sex | | yrs. last birthde | Months Days | | 8. Dete of Birth (Month, Day | Year) 9 | Birthplace (State or F | Foreign | | | |
| Director | 218-60-7180 | | JF 48 | Yrs | | | JULY 16 | , 1951 | MD. | | | | |
| 17 E F | Usual Residence of Decede 10e. Stete 10b. Co | | 100 | . City, Town or | Location | | | | 10d. Inside City Limits | | | | |
| lan Tre Marys 28a-1 sho notified at | MD. | N/A BALTIMORE | | | | | | 1 ☐ Yes 2 | | | | | |
| IIIa | 10e. Street and Number | | | | 10f. Zip Code | | 1 | Og. Citizen of Wha | What Country? | | | | |
| | 7008 EASTBE | ROOK AVE | | | 2122 | 4 | | USA | | | | | |
| (C) in the count of the count o | 11. Merital Status | 12. We | s Decedent Ever i | in U,S. 1 | 3. Was Decedent of I | Hispanic Origin? (Sp | pecify Yes or No- | 14. Race - | American Indian, | | | | |
| 002 002 003 004 | 3 ☐ Widowed 4 ☐ Divorced Year or Detes: | | | | 1 Yes 2 No | | rican, etc.) | Specify: | WHITE | | | | |
| 7+ein 121215-0 ac with 72 to so with 72 to Spiere. we then 'neture of the Medical. | 15. Dec (Specify only h | edent's Education | leted) | /G | cedent'a Usual Occu | during most of work | king | 16b. Kind of Busin | ess/Industry | | | | |
| mpi mpi mpi | Elementery/Secondary (0- | | lege (1-4or 5+) | | RKLIFT C | * | | DDDWD | 17 | | | | |
| C Published 2 | 10 TH 17. Father's Neme (First, Mic | ridle (ast) | | FO | RKLIFT C | 18. Mother's Nem | a /First Middle | BREWER | X | | | | |
| S Canada S C | ROBERT FALE | | | | | MARY GI | | | | | | | |
| Bary Bary | 19a. Informent's Neme/Reis | tionship (Type, Prin | nt) | 19b. Me | eiling Address (Stree | | | r, City or Town, Sta | ite, Zip Code) | | | | |
| M M | DONNA FALKENSTEIN/WIFE 7008 EASTBROOK AVE., BALTIMORE | | | | | | | IMORE. | MD. 2122 | 4 | | | |
| A property of the state of the | 20a. Method of Disposition | lethod of Disposition | | | | | | | | | | | |
| Page 1 | 17 Burial 2 Cremation 3 Removel Irom State 4 Donetion 5 Other (Specify) ST. STANISLAUS CEM. 1/28/2000 BALTIMORE, | | | | | | | | MORE, MD | | | | |
| Baltimore Baltimore semit Pages 1 Page | 21. Signature of Funeral Ser | vice Licensee | | | 22. Name and Addre | ess of Facility | | | | | | | |
| 0 88188 | Degalit | the Se | linas | bi | CHARLES | S. ZEILI | ER & SC | N, INC. | | | | | |
| 1-14 | 23a. Part1. Unter the disees shock in heert teilure. | e, or complications List only one caus | that caused the de on each line. | death. Do not | enter the mode of dy | ng, such as cardiac | or respiratory err | est, | Approximate Intervei Betwe | 24 en | | | |
| Physician | | | | , / | | | - | | Onset and De | eth | | | |
| /Medical Examiner | Immediate Cause (Finei disease or condition resulting in deeth) a. Cerebral Vascular Accordent 1 years | | | | | | | | UV | | | | |
| b b | | | Due t | to (or as a cons | sequence of): | | | | | | | | |
|), executed ini-transit | b | | | | | | | | | | | | |
| I Records, P.O. Box 68760, The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transi- | Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Finer Indexing | | | | | | | | | | | | |
| 68760, ificate be exe g physician a as the burial- | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): | | | | | | | | | | | | |
| K 68 riffice riffice as the as the | | | | | | | | | | | | | |
| Box Box Box eath cert for use | | d | | | | | | | 1 | | | | |
| O. Bo tha death c y the attence sched for us hysician | Part II. Other algnificant cor | ditions contributing | g to death but not | resulting in the | underlying cause gi | ven in Pert I. | 23b. Did to | obacco use contri | buta to the cause of | death? | | | |
| ds, P.O. Box (ires that the death certification dispended for use a by Physician/Med by Physician/Med | | | | | | | 1 U Y | aa 2 No 3 | Probably 4 Ur | nknown | | | |
| Division of Vital Records, or Attanding Physician: The law requires the after death. Director: After this certificate has been signed in by the funeral director, page 2 should be certification: To Be Completed by | | | | | | | 24a. Wes a | n autoney 3 | 4h Ware autonsy line | dinas | | | |
| Cord v require been si should is | | | | | | | perfor | med? | 4b. Ware autopsy line evailable prior to completion of cau | JSB | | | |
| The law requirements that has been single 2 should Completed | | | | | | | | and. | of death? | | | | |
| | 25. Was case referred to me | diani | | | | | 1 U Y | | 1 ☐ Yes 2 Ø N | 0 | | | |
| f Vita yelclen: s certific director, | examiner? | Hospital: | 1 🗆 lanationt (| | ient 3 DOA Ot | 26. Place of Deel | | | · · · · · · · · · · · · · · · · · · · | | | | |
| Of \Physic or this corral dire | 27. Manger of Death | 28a. | 1 ☐ Inpatient : | 28b. Time | of 28c. Inju | | | ence 6 Other ow injury occurred | Specify) | | | | |
| ion o oding Ph th.: After th e funeral | 1 Netural 5 Pe | ending restigation | (Month, Day Yea | r) Injur | | rk7 Yes 2 No | | | | | | | |
| Atter or desector by th | 3 ☐ Suicide 6 ☐ Co | ould not be zee. | Place of Injury - A | At home, ferm, | atreet, fectory, office | | 28f. Location (S City or Town | treet and Number | or Rural Route Numbe | 91, | | | |
| Ce digital Di | 4 Nonnoide | | building, etc. (Sp. | ecity) | | W | City of Your | i, Siate) | | | | | |
| Division of Vita to the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director, Medical Certification: To Be (| 29e. Certifier 1 Cert (Check only one) 1 Cert | ical Examiner: On | To the best of my the basis of exam I manner stated. | knowledge, de nination and/or | ath occurred at the ti investigation, in my | me, date end place, opinion, deeth occur | end due to the c red at the time, d | ause(s) and mannete and place, and | er as stated. I dua to the cause(s) | | | | |
| Within 2 To the comple | 29b. Signeture end fittle of ce | rtifier | La. An | a Dh | 29c. Licens | se number | 2 | 9d. Dete signed (/ | Aonth, Day, Year) | | | | |
| | Mun | · At | ano, | 1 DI | 1>11 ian | D536 | 42 . | Jan 26 | ,2000 | | | | |
| 3 | 30. Name and addrass of per | 40U 3 | cause of death (| ndm 23a) (Tyr | Drther | n Park | Way | Baltin | 10ne 212 | 14 | | | |
| State Registrar | 31. Dete filed (Month, Day, Y | (ear) 3 1 2000 | 32. Registrar's Si | ignature | 5 Span | 6 | | | | | | | |

DHMH 16 Rav 6/95

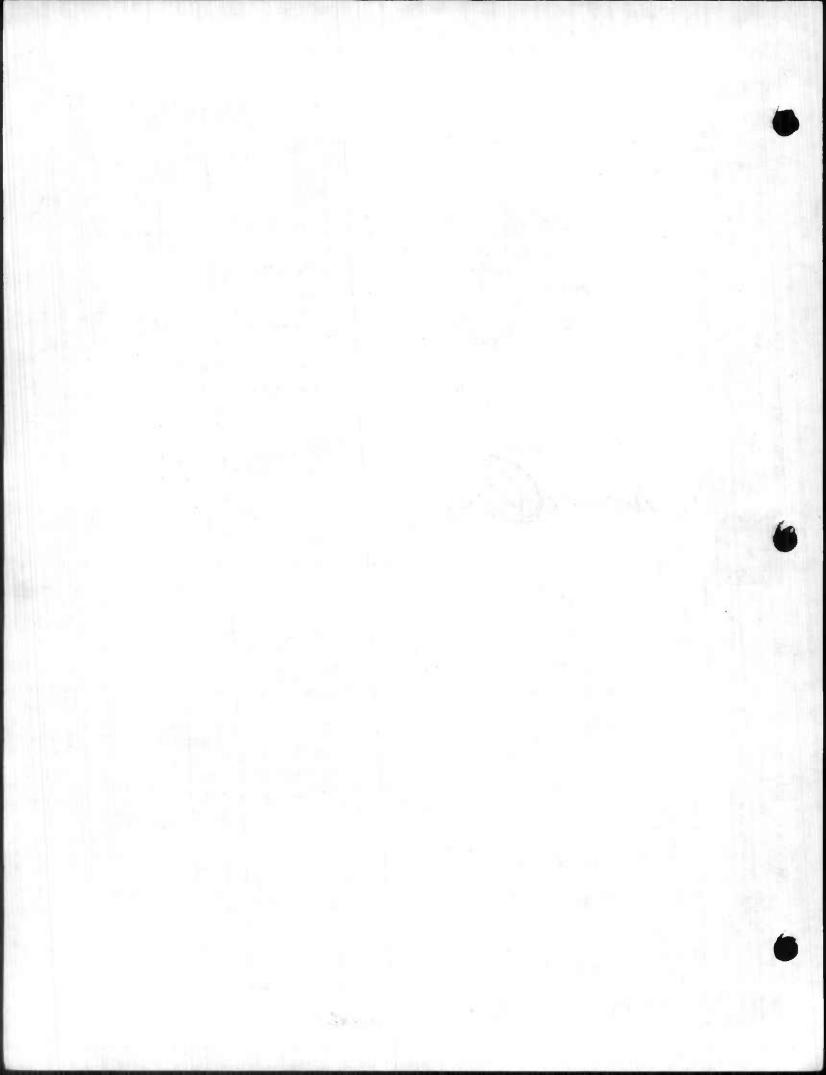


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

| 0 | 0 | 0 | 0 | 1 | 0 | 0 |
|---|---|---|---|---|---|---|
| 0 | U | U | 2 | 1 | 0 | 6 |

| | | | Certificate | e of Death | R | leg. No. | 0 02102 |
|--|--|--|--|--|-------------------------|---------------------|---|
| State of the last | 1. Decedent's Neme (First, Middle, L | nst) | | | 2. Dete of Dea Month | th Day | 3. Time of Death |
| Physician /Medical | DAWN | | 6 | ASKILL. | January | 0.1 | 2000 18:58 |
| Examiner | 4a Facility Neme (If not institution, ga | Harris Co. | | 4b. City, Town, o | r Location of Death | | of Death |
| | Johns Hop | kins Hospita | al | Baltim | ore | N | A |
| Funeral Director | 215-80-1712 | Sex 7. Age (In yrs. 1 | Yrs. If Under Months | 1 Year If Under 24 Hr Days Hours Mi | | Year) | Birthplace (State or Foreign Country) M D |
| P . | Usual Residence of Decedent 10a. State 10b. County | 140- 04 | v. Town or Location | | | | Table to the One bloom |
| ahou a | | | 10d. Inside City Limit | | | | |
| ot de s | MD NA | В | altimore | | | | 77.7 |
| 72 hours after death with the Maryland natural, or Itams 23a or 28a-f show stell Examiner must be notified at sted by Funeral Director | 10e. Street and Number 2403 Bridge H | ampton Dr. A | pt"D" 10f. Zip | 21234 | | 0g. Citizen of \USA | Vhat Country? |
| 200 des | 11. Marital Status | 12. Was Decedent Ever in U. Armed Forces? | S. 13. Wes Decede | ent of Hispanic Origin? | (Specify Yes or No- | | e - American Indian, ck, White, etc. |
| ar, or the by Fu | 1 🔀 Never Married 2 🗆 Merried 3 🗆 Widowed 4 🗆 Divorced | 0.000 | No Specify: | nio ruogn, dio., | Specify | | |
| or than 'natural', t, the tracel Ex | 15. Decedent's E | | 16a. Decedent's Usual | Occupation | natina | 16b. Kind of Bo | usiness/Industry |
| within 7 | (Specify only highest gi Elementary/Secondary (0-12) | life. DO NOT use | k done during most of we e retired) | Urking | | | |
| Hygien Hygien Hygien Con | 10th Grade | NA | Cashier | | | Compa | any |
| EISE A | 17. Father's Name (First, Middle, Las |) | | 18. Mother's N | ame (First, Middle, I | Maiden Suman | ne) |
| | William | Gaskill | | Barbai | | | |
| 2 should and Mer la marks aumatic | 19e. Informent's Neme/Relationship | (Type, Print) | 19b. Meiling Address | (Street and Number or I | Rural Route Number | r, City or Town, | State, Zip Code) MD |
| 4450 | Barbara G | askill | 2403 Brid | dge Hampto | on Drive | Apt"I | " Baltimore |
| of Heal | 20a. Method of Disposition | | Place of Disposition (Name emetery, crematory or other | e of her place) | Date | 20c. Location - | City or Town, Stete |
| | 1 Burial 2 Cremation 3 (| (fy) A | rbutus Men | n.Pk. Cem | 02-01- | 2000 1 | rbutus, MD. |
| 교통론을 . | 21 Significant of Funeral Service Lice | | | | 1 | | yland 21202 |
| Department of the partment of | (Depris | 11/11 | WM C | . March Fi | | | |
| | 78a Ball 1 Foter the disease or con | policy temperature regress the deat | | | | | Approximate |
| 1 | shock, or heart failure. List only | one cause on each line. | | or cynig, oddir as odior | ao or rospiratory are | 031, | Interval Between Onset and Death |
| nysician Medical | Immediate Cause (Final | | 0 | 11. | | | |
| xaminer | disease or condition resulting in death) | . CENTRAL | | MYOLING | OLXSIS | | TWO WEEK |
| 5 | | | or es e consequence of): | | | | |
| ng ng | | b. DIABETT | ES MELLI | rus . | | | 124 YEARS |
| physician and the burial-transit | Sequentiafly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | Due to (o | or es e consequence of): | 7 | | | t |
| as the buriel-transit | Cause (Disease or injury | c END ST | AGE KENA | 2 DISEASE | | | ONE YEAR |
| physicia se the bur edical | resulting in death) Last | Due to (o | r as a consequence of): | | | | |
| ding | | d | | | | | |
| attendin for usa clan/N | | | | | | | |
| igned by the attending be detached for usa a by Physician/M | Part II. Other algnificant conditions | contributing to death but not res | ulting in the underlying ca | use given in Part f. | 23b. Did to | obacco use co | ntribute to the cause of deat |
| P detay | | | | | 1 🗆 Y | es 2/0 No | 3 Probably 4 Unkno |
| It has been signed by the attendit page 2 should be detached for use Completed by PhysicianA | | | | | | | I |
| page 2 should | | | | | 24a. Wes e perfor | n autopsy med? | 24b. Were autopsy findings available prior to completion of cause |
| has by ga 2 at | | | | | | | of death? |
| Page Dom | | | | | 1 🗆 Y | es 2 No | 1 ☐ Yes 2 No |
| | 25. Wes case referred to medical | | | 26. Place of D | eath (Check only or | ne) | |
| | axaminer? | Hospital: | ER/Outpatient 3 DO | Other: 4 Nursing | Home 5 ☐ Resid | ence 6 Oth | er (Specify) |
| erald orald | 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | | 3c. Injury at Work? | 28d. Describe h | ow injury occur | red |
| th. After tuner tion | 1 Netural 5 Pending 2 Accident investigation | | fnjury M | 1 Yes 2 No | | | |
| at Director: After the In by the funeral Certification: | 3 ☐ Suicide 6 ☐ Could not I | 288. Place of Injury - At no | ome, farm, street, factory, | office | | | per or Rural Route Number, |
| Direction of the property of t | 4 Homicide | building, etc. (Specify | y) | | City or Tow | n, State) | |
| within 24 hours after death. To the Funeral Director: After complately filled in by the fune Medical Certification | | nysician: To the best of my kno- miner: On the basis of examine | | | | | |
| within To the comple | 29b. Signature and title of certifier | and manner stated. | 290 | License number | | 19rl Date sinne | d (Month, Day, Year) |
| ¥ 1 8 | The state of the s | | | | | | |
| | Doods | e, MD | K | -00 | 0 | MUMA | 4 26,2000 |
| | 30. Neme and address of person who | completed cause of death (Item | | | | | |
| | DANIELBROD | E 600 NOR | TH WOLFE J | T, BACTIM | DRE, M | 2/2 | 87 |
| State | 31. Date filed (Month, Day, Year) | 32 Registrar's Signs | Acces | | | | |
| Registrar | JAN 3 1 20 | JU Dune | B. Spar | No! | | | |



Day

4c. County of Deeth

10g. Citizen of What Country?

14. Race - American Indian. Bleck, White, etc.

Specify: Black

various trades

16b. Kind of Business/Industry

Christian

20c. Location - City or Town, State

USA

Physician /Medical Examiner

Genette Gaither 4a Facility Name (If not institution, give street and number) Johns Hopkins Hospital

January 25, 4b. City, Town, or Location of Death

3. Time of Death a m 2000 10:49

Funeral

10s. State

 Birthplace (State or Foreign Country) NC

10d. Inside City Limits

1X Yes 2 No

Director

Director

þ

frema 23a or 2

Pages 1 and 2 should be filed within 72 hours effect mind of Health and Mental Hyglens.
This if New 37 is merked other than "natural", or the layer than the second of the Medical Especial and the control of the Medical Especial and the control of the Medical Especial and the Medical Especial and

21215-0020

Baltimore, Maryland Department of important: If any injury or Physician /Medical Examiner

MUNITY E

attending physician and for use as the burief-trensit this certificate has 8 funeral After To the Hospital or Attending within 24 hours effer deeth. To the Funeral Director: Afte completely filled in by the fun.

The law requires that the deeth certificete be axecuted

Box 68760,

P.0.

Records,

of Vital Physician:

Division Attending

Completed Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Physician/Medical Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. by Completed Certification: To 27. Manner of Death 2 Accident 3 ☐ Suicide 4 Homicide

7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) O8-27-19 5. Social Security Number 1 M 2 F 237-38-3554 **Usual Residence of Decedent** 10b. County 10c. City. Town or Location MD NA Baltimore 10e. Street and Number 10f. Zip Code 2635 Garrett Avenue 21218 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 22 D\$90 If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 N Married 1 ☐ Yes 2 ☐ No 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Unknown NA Laborer 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Walter Howell Esther 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2635 Garrett Avenue Baltimore, MD. 21218 Reginald Gaither 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) ↑ Burial 2 Cremation 3 Removel from State 4 Donation 5 Other (Specify) Voshell Mem. Gardens 02-03-2000 Dundalk, MD 21. Signature of Funeral Service License 22. Name and Address of Facility semand Johnson 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line.

Baltimore, Maryland 21202 WM.C. March FH 1101 E. North Avenue

Immediate Cause (Final disease or condition resulting in death)

STAGE RENAL DISEASE

Approximete Interval Between Onset and Deeth WEEKS

Due to (or as a consequence of):

Due to (or es a consequence of):

Due to (or as a consequence of):

23b. Did tobacco use contribute to the cause of death?

HYPERTENSION

MALNUTRITION

1 Yes 2 No 3 Probably Unknown

24a. Was an autopsy performed?

24b. Were autopsy findings available prior to completion of cause of death?

26. Place of Death (Check only one)

1 Yes 2 No

25. Was case referred to medical examiner? 1 Yes 2 No

5 Pending investigation

6 Could not be determined

28a. Date of tnjury (Month, Day Year)

Hospital: 2 ER/Outpatient 3 DOA 28b. Time of Injury

28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28c. Injury at Work?

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

edical

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated.

29b. Signature and title of certified · MD 29c. License number RES-000 29d. Date signed (Month, Day, Year) JANNARY 31, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

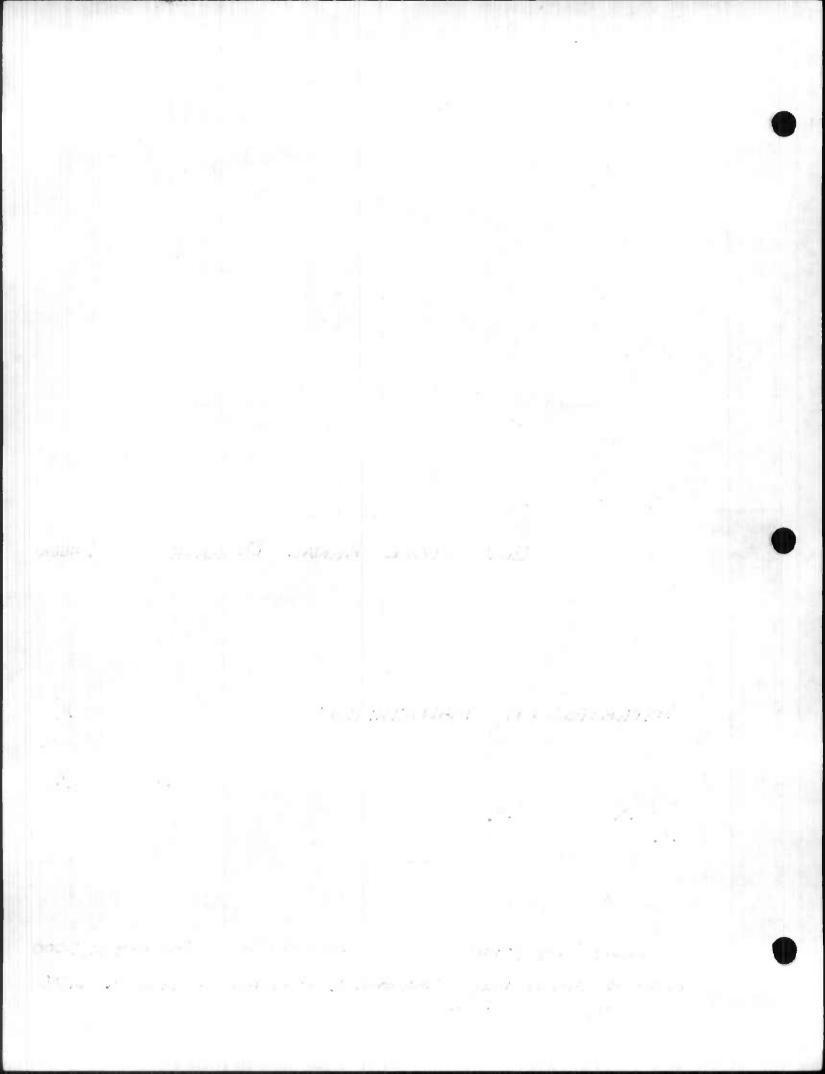
JOHNS HOPKINS HISPITAL BALTIMORE, MO 21205 - ROTHMAN M.D

31. Date filed (Month, Day, Year)
JAN 3 1 2000

32. Registrar's Signature

oaks

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death ^{Dey}2000 **Physician** Month Emma G. Harvey Jan. 24 9:15 P.M. /Medical 4e. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Chesapeake Nursing Home Arnold Anne Arundel If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthdey) Birthplece (State or Foreign Country) Funeral 1 M 2 F 212 28 5368 88 Yrs. Director Aug. 22,1911 Maryland Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23s or 28s-f ahov rolcal Examiner must be notified at 1 ☐ Yes 2 No Maryland Anne Arundel Directo Millersville 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 8305 Brightview Court 21108 United States Funeral 12. Wes Decedent Ever In U,S. Armed Forces?
1 Yes 2 No If Yes, Give Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Maritel Stetus 14. Rece - American Indian. Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 □ Divorced White Year or Dates: Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be Louis Bauer Gina (Unavailable) 0 19e. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Patrick Carberry Grandson 10298 Mulberry Way Largo Florida 20b. Place of Disposition (Name of cametery, cremetory or other place) Jan. 29, Det 000 20c. Location - City or Town, State 20e. Method of Disposition 1 Buriel 2 Cremetion 3 Removel from State 4 Donetion 5 Other (Specify) permit. Pege Department of Important: If any injury or once. Lakemont Memorial Gardens Davidsonville Maryland 21. Signeture of Funerel Service Line 22. Nome and Address of Facility Robert E. Evans Funeral Home, Inc. 16000 Annapolis Rd. Bowie Maryland 20715 23a. Pert1. Enter the disease, or compilcation othet caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory arrest, shock, or heart feiture. List only one ceuse on each line. Approximete Interval Between Onset end Deeth **Physician** /Medical fmmediete Ceuse (Finel diseese or condition resulting In death) Examiner Examiner bunel-transi Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Couse (Disease or Injury that initiated events resulting in deeth) Last Due to (or es e consequenca of): Physician/Medical Due to (or es e consequenca of): Part II, Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 25 No 3 ☐ Probably 4 ☐ Unknown 24b. Were eutopsy findings aveilable prior to completion of cause of death? Completed 24e. Wes an autopsy performed? 1 ☐ Yes 2 ☐ No Be 25. Wes case referred to medical 28. Plece of Deeth (Check only one) exeminer? Other: 4 Jursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1□ Yes 2☑ No 0 28e. Dete of Injury (Month, Day Year) 28c. fnjury et Work? 27. Menner of Deeth 28b. Time of 28d. Describe how Injury occurred Certification: 1 Neturel 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 8 Could not be determined 3 Sulcide 28e. Pleca of Injury - At home, ferm, street, fectory, office bullding, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide

P.O. Box 68760,

the death certificate be executed physician the USB 88 ō ed by the e signed by t certificate Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, in filled in by the

filed within 72 hours after death with the Meryland

than

Peges 1 end 2 should be filed nent of Heelth end Mental Hygid int: If Nem 27 is marked other

altimore, Maryland 21215-0020

State Registrar

edicai

29a. Certifier

29b. Signeture end title of certifier

mack Attending Dodor

29c. License number

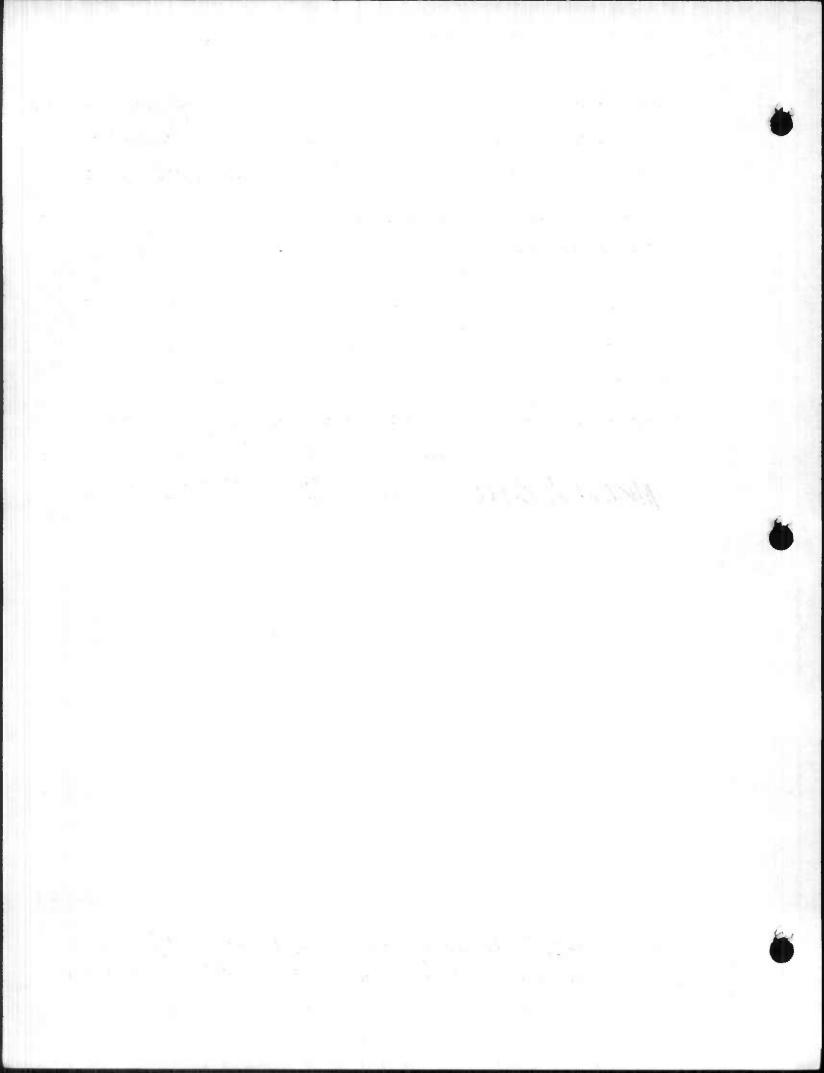
29d. Dete signed (Month, Dey, Year)

30. Name end address of person who completed cause of deeth (Item 26e) (Type, Print) RITCHIE AWY, PASADENA, C-V. CYRIAC. M.D 8109

32. Registrer's Signeture

Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete and piece, and due to the ceuse(s) end menner as steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end piaca, end due to the ceuse(s) end menner steted.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - ' Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** TEBROK 27 INJE 0 2000 PM /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Howard UMBIA GNERM HOWARI OUNTY HOS PITEL 01 H Under 24 Hrs. 8. Date of Birth (Month, Day, Y Jan. 10, If Under 1 Year Months Days 7. Age (In yrs. last birthday) 9. Birthplaca (State or Foreign Country) Md • 5. Social Security Number 213-22-1969 6. Sex Year) 1905 **Funeral** Days 1 M 2KM Director Usual Residence of Decedent the Maryland 10b. County Anne Arundel 10a. State 10c. City, Town or Location Hanover 10d. Inside City Limits r 28a-f show Md. 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene.
Important: If them 27 is merked other than "natural", or frems 23a or 2 any Injury or other traumstic avant 7230 Race Road 21076 USA Funeral 12. Was Decedent Ever in U,S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, Whita, etc. 11. Marital Status 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: Black altimore, Maryland 21215-0020 1 Yes 20No Specify: à 3 Nidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Flamentary/Secondery (0-12) College (1-4or 5+) C & T Shoppe Seamstress 17. Father's Name (1713), 1711 Thomas Johnson Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Florence Cooke 2 19a. Informant's Name/Relationship (Type, Print)
Laverna H. Hall 19b Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 487 Queenstown Road Severn, Md. 21144 daughter 20a. Method of Disposition

1 Deurial 2 DCremation 3 Removal from State 20b. Place of Disposition (Name of Dete 20c. Location - City or Town, State Saints Rest Cemetery Feb. 2 Harmons, Md. 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility Nutter Funeral Homes, 21. Signeture of Funeral Service Licensee 2501 Gwynns Falls PKWY Baltimore, Md. 21216 Lutter Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. **Physician** Immediate Ceuse (Finel disease or condition resulting In death) /Medical 1 DAY Examiner Due to (or as a consequence of): Examiner TIPLE The law requires that the death certificate be executed the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Last Due to (or as a consequence of): and Box 68760. Physician/Medical Due to (or as a consequence of): 8 for use P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by I 1□ Yes 2♥No 3 Probably 4 Unknown DEMENTA Medical Certification: To Be Completed by Records. 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate has page 2 2 No 1 Yes 1 Tyes of Vital or Attending Physician: 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) 1□ Yes 2 No Hospital: 1 Inpatient 2 □ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3 DOA this 28a. Dete of Injury (Month, Dey Year) funaral 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Aftar 1 Division 1 Netural 5 Pending Investigation To the Funeral Director: All completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, atreet, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 | Homicide To the Hospital 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2000 MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mn 21042 BATTMORE NATIONAL RIKE 9051 am >HEIKI+

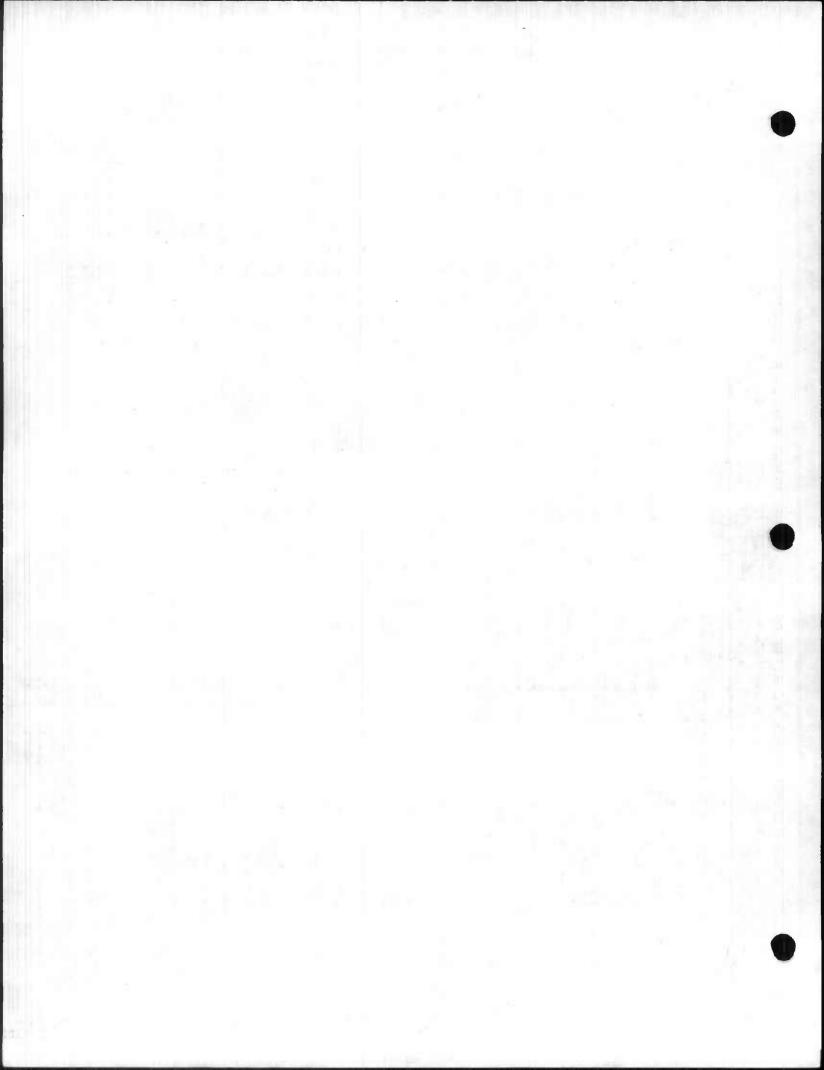
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State

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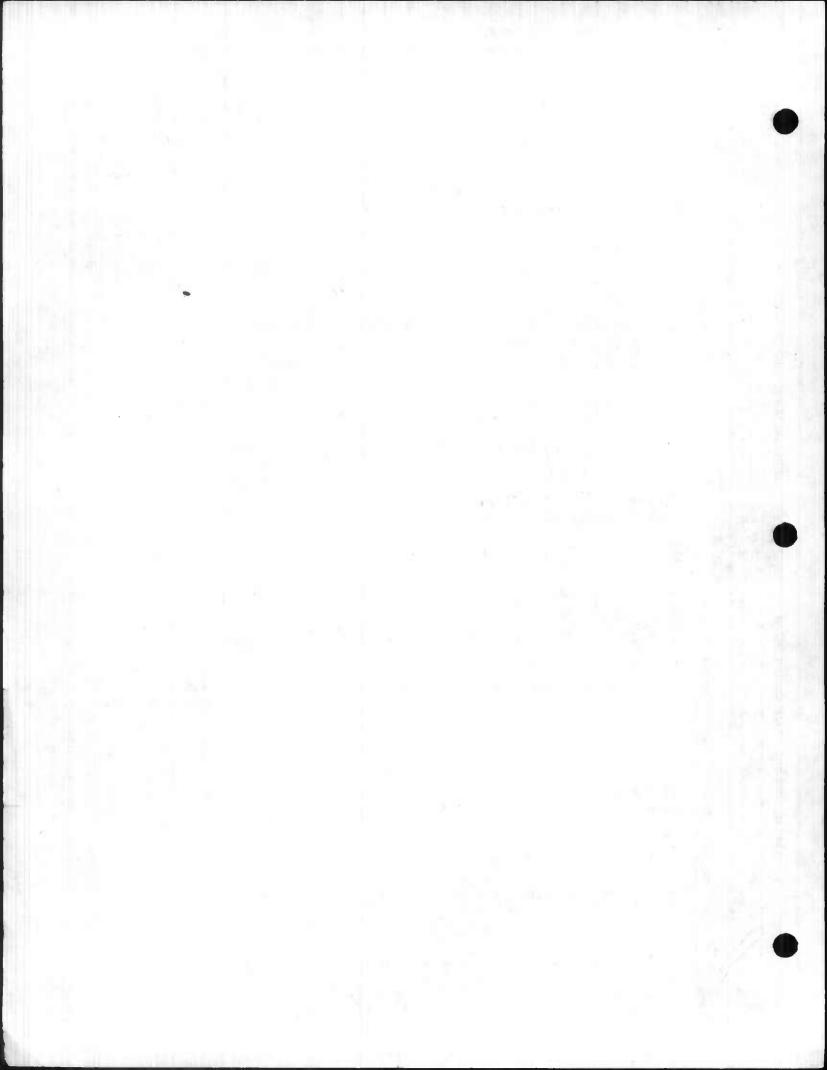
31. Date filed (Mooth

32. Registrar's Signature



Piease Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Year 1:18 pm James JAN 26 2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Beltim are Nouth Mours Min. 8. Date of Birth (Month, Day, Year) CHY Hospital 5. Social Security Number 7. Age (In yrs. last birthday) 46 yrs Birthplace (State or Foreign Country) **Funeral** 216-58-4470 XXM 2 F Director Usual Residence of Decedent pernit. Pages 1 and 2 should be flied within 72 hours after deeth with the Marylen Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f ahow with jury or other treumatic avant, the Medical Examiner must be notified as once. 10c. City, Town or Location 10d. Inside City Limits Md. Baltimore Randallstown 1 Yas AND No Director 10f. Zip Code 21244 10e, Street and Number 10g. Citizen of What Country? 7909 Chipper Road USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, Whita, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Narried aitimore, Maryland 21215-0020 1 ☐ Yes 2 XXX Specify: Black Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12th Grade College (1-4or 5+) James Police Officer Baltimore City Police 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charlie Hicks Carrie Weathers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Katherine Hicks wife 7909 Chipper Road Randallstown, Md. 21244 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 XX urial 2 ☐ Cremation 3 ☐ Femoval from State Jan. 31 Baltimore, Md. Woodlawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify 21. Signatury of Funeral Service Lice 22. Name and Address of Facility Nutter Funeral Homes, 2501 Gwynns Falls PKWY Baltimore, Md. 21216 EN tions that coursed the death. Do not enter the mode of dying, such as cardiec or respiretory arrest, cause on each line. 23a. Part¹. Enter the diseas shock, or heart failure. e, or com List only Approximate tnterval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Myocardial Examiner Due to (or es a consequence of) Examiner Atherosclerotic physician and the burlei-transit or Attending Physician: The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical Due to (or as a consequence of): signed by the attending p d be detached for use as P.0. Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the causa of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vitai Records, Completed by cata has been si, 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? 1 ☐ Yas 2 No 1 ☐ Yes 2 No certificata funeral director, B 25. Was case referred to medical axaminer? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 8 Other (Specify) Certification: To 1⊠Yes 2□ No ≥ER/Outpatient 3□ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury al Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation 1° Divietural To the Hospital or Attending within 24 hours after death.
To the Euneral Director; After completely filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 12\$Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and #\$\$ of certifier 29c. License number 29d. Date signed (Month, Day, Year) 26,2000 04376 JAN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Franklines 32. And him is Signature State Luu oaks Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amended Item#5 perFHG781 3/14/2000 EW Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Day Van Yolonda R. Harrison January 25,2000 5:10AM 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Spring Silver Montgomery If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 7. Age (In yrs. last birthdey) 5. Social Segurity Number Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) Months Days 1 ☐ M 2 🖾 F $167 - \frac{36}{36} - 8022$ Yrs 80 4,1919 Pennsylvania Aug. Usuai Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Silver Spring Maryland Montgomery 10f. Zin Code 10g, Citizen of What Country? 3700 International Dr. #314 20906 United States 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Merried 2 ☐ Married Specify: 3€34Vidowed 4 □ Divorced White 15. Decadent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Homemaker "Own Home. 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Samuel Roncace Maria Tribian 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Mary Louise Willis/daughter 20 Crosswood Ct. Burtonsville, MD. 20866 20a. Method of Disposition 20b. Placa of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State ation 3 Removal from State 1 ☐ Burial 20 Cremation Northern VA. Crematory 1/28 Arlington, VA. 22. Name end Address of Fecility Takoma Funeral Home. 254 Carroll St. NW. Washington, DC.20012 The disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, and failure. List only one cause on each line. Approximete interval Between Onset and Deeth Immediate Cause (Final disease or condition resulting In death) Cerebrovasclar Accident Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24e. Was an autopsy performed? 1 Yes ZENo 1 ☐ Yes 2 ☐ No 26. Piace of Death (Check only one)

Physician /Medical Examiner

thet the death certificate be axecuted

Box 68760.

P.O.

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Division of Vital

Hospital or Attending Physician:

To the within To the

24 hours a

Department of Heeith ar Important: If Item 27 is eny injury or other treu

Physician

/Medical

Examiner

Funeral

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Completed

treumstic event, the Medical Examiner must be notified at

the Marylend

72 hours effer

Peges 1 and 2 should be filed within 7 nent of Heelth and Mentel Hygiane. Int: If Item 27 is marked other than °1

Baltimore, Maryland 21215-0020

buriel-transi physicien s the buriel for use es signed t page 2 funeral director. this After death. ours after death.

erel Director: A
filled in by the fi

Examiner Physician/Medical þ Completed Be Certification: To

Lung Cancer 25. Was case referred to medical exeminer? 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Manpatient 2 ER/Outpetient 3 DOA 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28e. Dete of tnjury (Month, Dev Year) 28c. Injury et Work? 1 Neturel 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Placa of injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide 29a. Certifier 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted. 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s)

29b. Signature and title of certifier

-

eidmar M.

29c. License number 037801 29d. Date signed (Month, Dey, Year) January 26, 2000

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

110 Irving St. NW #1A-50 Washington, DC. 20010 Aimee J. Seidman, MD.

State Registrar

Medical

31. Dete filed (Month, Dey, Year)

JAN 3 1 2000

32. Redistrer's Signeture

and manner stated.

THE PERSON REPORT OF THE PERSON

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMENDEO ITEMS #10b,10c PER FH G779 1/31/2000 AH Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 22-2000 Year **Physician** James Vincent Johnson, Sr. JAN-/Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Sinai Hospital Baltimore H Under 24 Hrs 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1₩# 2□F 248-72-9528 57 Yrs. Director June 12, 1942 NY Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Name 23a or 28a-f show Baltimore PIKESVILLE Fakesyllide Md. XXYes 2 No Director BALTIMORE 10f. Zip Code 21 208 10g. Citizen of What Country? USA 10e. Street and Number 8227 Streamwood Drive Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, atc. 11. Marital Status 1 Yes RNO If Yes, Give Year or Dates: 1 Never Married 2KN Married natural, or Black 21215-0020 1 Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working tife. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 5 College (1-4or 5+) Care Rehab Elementary/Secondary (0-12) Teacher Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be III ment of Health and Mental H ant: If Item 27 is marked off å William Johnson Annie-Sue Anderson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8227 Streamwood Drive Pikesville, Md. 21208 Sandra B. Johnson wife 20b. Place of Disposition (Name of 20c. Location - City or Town, Stete 20s. Method of Disposition 1X Burial 2 □ Cremetion 3 □ Removal from Statu Mt. Olive U.M.C. Cemetery Jan.29 Randallstown, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Nutter Funeral Homes, Inc. of Funeral Service bicens 2501 Gwynns Falls PKWY Baltimore, Md. 21216 Emy 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on ee in line. Approximate Intervel Between Onset and Death Physician Cerebrel on cular accident /Medical Immediata Cause (Final disease or condition resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events. s thysician a Physician/Medical nuse (UISORSO OF INJU at initiated events sulting in death) Last Due to (or as a consequence of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Nonknown 4 algned of be def Records, à 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 88 25. Was case referred to medical axaminer? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA = 28d. Describe how injury occurred 27. Manger of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: Affar 1 Natural 5 Pending 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide

Division of Vital Attending Depital or Attand hours after death uneral Director.

A Funeral Di To the Hosp within 24 ho To the Furn completely

State Registrar

Medical

4 Homicide

(Check only one)

29b. Signature and title of certifier

29a, Certifier

1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

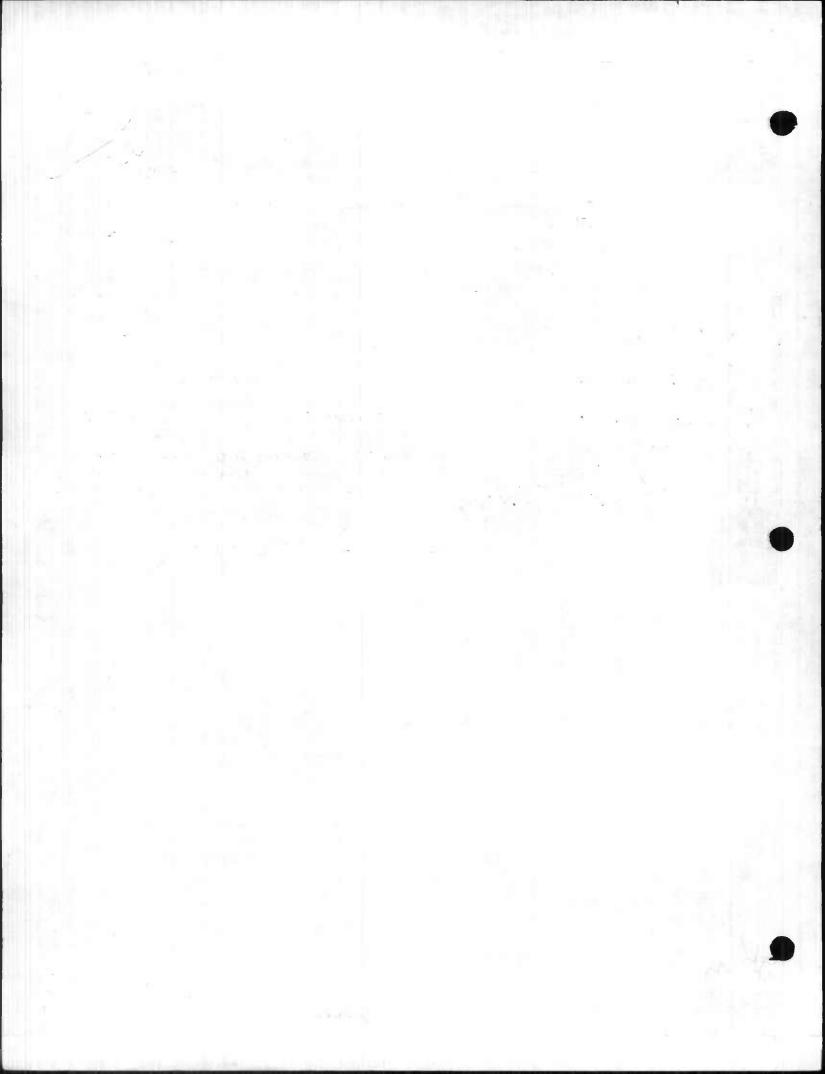
28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rurat Route Number, City or Town, State)

cause of death, (Horn 23a) (Type, Print) Lave 24 S4 W Beluelere are, Ballimore

32. Registrar's Signature

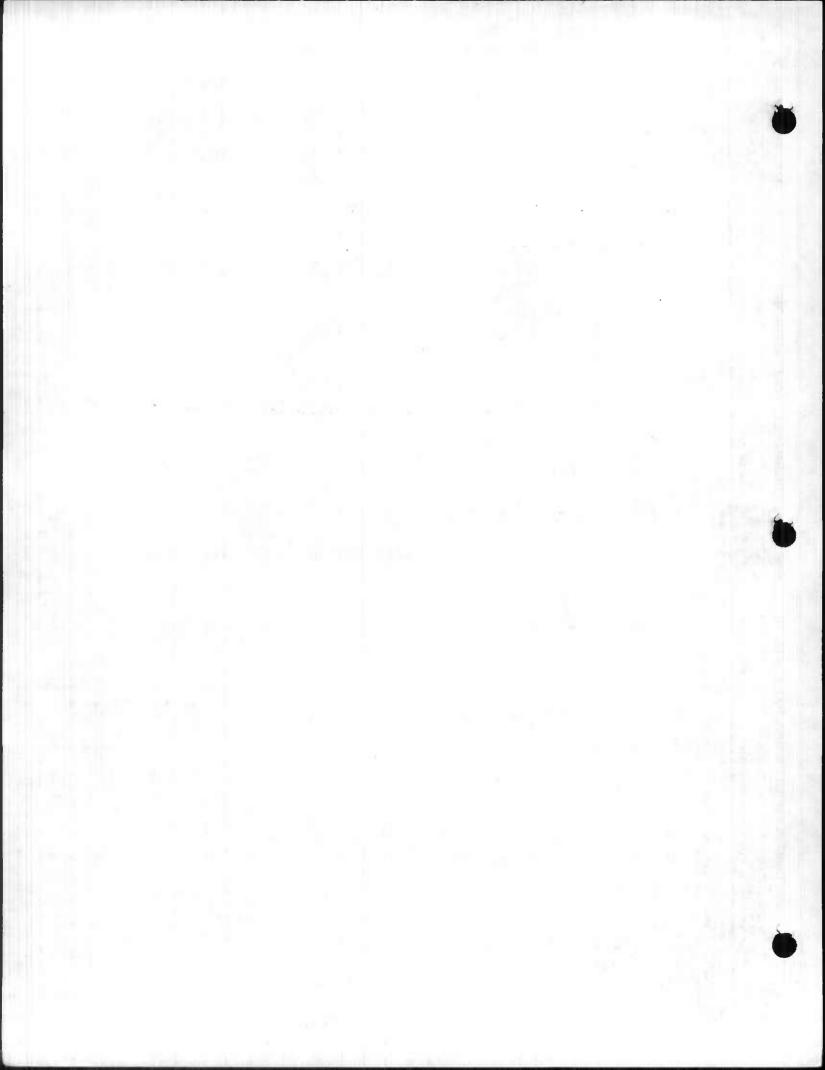


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Deeth 9:02a.m. Emma **Physician** Jackson January 26, 2000 /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3104 Gwynns Falls PKWY 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Days 1□ M 35 F 213-26-6565 92 Yrs. Director Sept. 18, 1907 Va **Usual Residence of Decedent** 10a. State 10c. City, Town or Location 10d. Inside City Limits Baltimore Md. n/a XXYes 2 No I Hygiene. other than "natural", or hams 23s or 25s-1 a-vent, the Medical Examiner must be notified Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3104 Gwynns Falls PKWY 21216 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after with rid (Health and Mental Hygiene, mit if flem 27 is merked other than "natural", or his ury or other traumatic event, the <u>Medical Examines</u> 1 Never Married 2 Married 1 Yes 20X No If Yes, Give Year or Dates: Specify: Black altimore, Maryland 21215-0020 1 Yes 2 No Specify: à 3 ⊠ Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 8th Grade College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Lucy Jackson Charles Jordan 19e. Informent's Neme/Relationship (Type, Print) Nellie Jackson 196. Mailing Address (Street and Number or Rural Route Number, City or Town, State Zip Code) 3104 Gwynns Falls PKWY Baltimore, Md. 21216 daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date ► Burial 2 Cremetion 3 Removel from State Ridge Cemetery Feb. 4 Baltimore md 22. Name and Address of Facility Nutter Funeral Homes, Inc 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licer 2501 Gwynns Falls PKWY Baltimore, Md. 21216 comes 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Deeth Do not enter the mode of dying, such as cardiac or respiratory arrest, **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical tre lauduros Examiner Examiner attending physician and for use as the burial-transit The law requires that the death certificate be asseuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical Due to (or as a consequence of) Part II. Other, significant conditions contributing to death but not resulting in the underlying cause given in Pert I. P.0 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Mine Rei lension of Vital Records, þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en autopsy performed? Completed page 2 should this certificate has 1 Yes 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attanding Physician: within 24 hours after death.

To the Funeral Director: After this certifica completally filled in by the funeral director; gompletally filled in by the funeral director; to the funeral director director directors. Be 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Magner of Death 28d. Describe how injury occurred Certification: 28a. Date of tnjury (Month, Day Year) 28b. Time of 28c. Injury at Work? Division 1 Netural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 27 0 00 30. Name and address of person who completed cause death (Item 23a) (Type, Print) Road 38 8 31. Date filed (Month, Day, Year) 32. Registray's Signature State Senera Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death amend item 5 per fh G780 2/14/00 yg Reg. No 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Dey 2000

IANUALY 28, 2000

mation of Death 4c. County of Death **Physician** 14:47 ELLSWORTH /Medical Town, or Location of Death Name (If not institution, give street and number Examiner MORE # Under 1 Months B. Dete of Birth
Jan 9, 1918 Age (In yrs. last birthday) 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** Days M 2DF 82 **218-18-1299** 1229 Yrs Maryland Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits N/A 1 Yes 2 No MD Director Baltimore 238-1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? à 5006 E. Oliver St Name 23a 21205 United States 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 11. Merital Status 72 hours after 1 Never Married 2 Merried 1 XYes 2 No If Yes, Give WIII Year or Dates: ò Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be fisid within Department of Health and Merial Hygeno. Important if Item 27 is marked other than "1 any Injury or other traumetic event, the Med Elementery/Secondary (0-12) College (1-4or 5+) Receiving Clerk Commercial Credit Corp 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be George Dorsey To Keene 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Helen M. Keene/wife 5006 E. Oliver St. Baltimore, MD 21205 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, Stata 1 ☐ Burial 2 Cremetion 3 ☐ Removel from State Chesapeake Crematory 1-31-00 Beltsville, MD 4 Donetion 5 Other (Specify) re of Funeral Service Licen 22. Name and Address of Facility CAFA Stephen D. Lohmann, P.A. 8717 Green Pastures Dr., Baltimore, MD 21286 23a. Pertt. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Deeth **Physician** /Medical Immediate Cause (Finel disease or condition resulting in deeth) 1999 **Examiner** Physician/Medical Examiner physician and s the burial-transit that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Due to (or as e consequence of): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t 3 Probably 4 Unknown 1 Yea 2 No Records, þ Completed 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? page 2 SENO 1 Yes 2 No Division of Vital or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Menner of Death 28d. Describe how injury occurred 28a. Dete of Injury (Month, Day Year) 28h Time of 28c. tnjury at Work? 1 Netural 2 Accident 5 Pending death. 1 Tyes 2 No investigation after death 3 Suicide 6 Could not be 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 4 Homicide filled in 24 hours a Hospital 154 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. within 24 hour To the Fune completely file edical 29a. Certifier (Check only one) 94 29b. Signature end title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) Ruar RES-001

State Registrar

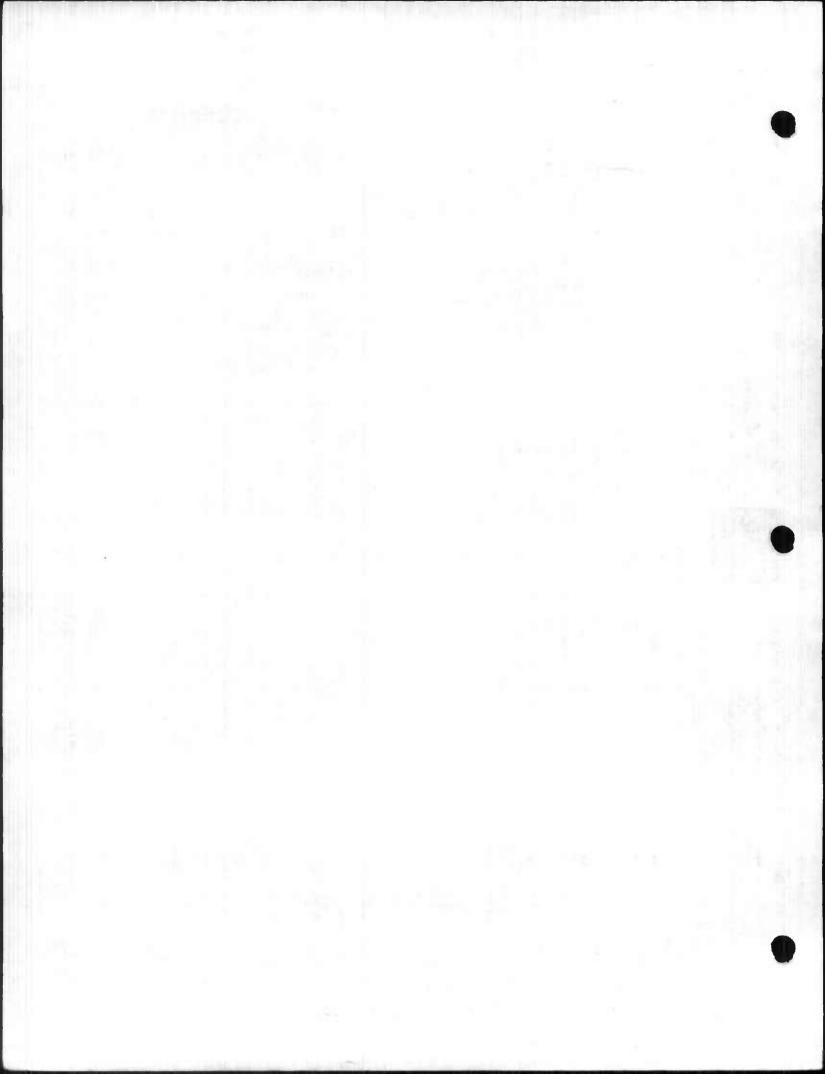
DHMH 16 Rev 6/95

DAVID A. ZIDAR Date filed (Month, Day, Year) JAN 3 1 2000 TOWER 101

32. Pegistrar's Signature

30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

Sparks



and Mental Hygiene

| 00-0355 | -510 | | | | | State of | Mary | land | Department of Health |
|--------------|--------|-----|------|----|-----|----------|------|------|---|
| AMEND | ITEMS: | #23 | PART | I, | 27, | 28A-F | PER | MEO | Department of Health a Certificate of Death |

| | AMEND IT | EMS: #23 PART I | | ER MEO | Certificate o | f Death | 2. Date of Dea | | 3. Tima of Death | |
|---|--|---|--|--|--|---|--|--|--|--|
| | Physician /Medical Examiner | 4a Facility Nama (If not institu | tion, give street end number, | LYNO | CH | 4b. City, Town, or L | | 4c. County | of Death | |
| | Funeral Director | JOHNS HOPKIN 5. Social Security Number 218-44-6357 | | ga (In yrs. last bii 55 | thday) If Under 1 Ye. Months Day | | 8. Data of Birt (Month, Day | r, Year) | N/A 9. Birthplaca (State or Foreign Country) NORTHCAROLIN | |
| | 2-0020 72 hours after deeth with the Maryland natural;, or thems 23a or 28a-f show deal Examiner must be notified at each by Funeral Director | Usual Rasidence of Decedant 10a. Stata 10b. Cou MARYLAND | nty N/A | 10c. City, Tow BA | n or Location LTIMORE | | | | 10d. Inside City Limits 1 Yes 2 □ No | |
| | | | EL STREET | | 10f. Zip Code | 21213 | | What Country? | | |
| 020 vurs after deeth vurs after deeth vurs after deeth vurs after 23 Exercises 23 Exercises 23 Exercises 23 | 3 ☐ Widowed 4 ☐ Divor | H Vas Giva | 7 | 13. Was Decedent of If Yas, specify Co | as Decedent of Hispanlc Orlgin? (Specify Yas Yas, specify Cuban, Maxican, Puarto Rican, at □ Yes 2 \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ | | | e - American Indian, sk, Whita, atc. AMERICAN : | | |
| 21215-0 | Maryland 2121 nd 2 should be filed within nd 2 should be filed within the end Mental thygiena. 27 ie marked other than " t raumatic event, the Me To Be Comple | 15. Dece (Specify only high Elementary/Secondary (0-1 | N/A | 5+) | 16a. Decedant's Usual Occupation (Give kind of work done during most of wo lifle. DO NOT use retired) MECHANIC | | | PERFEC | of Businass/Industry | |
| /land | | 17. Fathar's Nama (First, Mide | | | | | a (First, Middle, Y LYNC | lle, Maiden Surname) CH | | |
| | | 19a. Informant's Name/Ralati | | | . Mailing Addrass (Stre 922 MCELD | | | or, City or Town, O, MD. | State, Zip Code) | |
| Baltimore, | 8 7 E 0 | 20a. Mathod of Disposition 1 Burial 2 Cremation 3 Ramoval from State 4 Donation 5 Othar (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) LYNCH CEMETERY JAN. 28, 2000 H | | | | | | | cation - City or Town, Stata HALIFAX, CO. | |
| Ball | pemit. Pege Department of important: if any injury or ange. | 23. Part : Enter the disease shock, or heart failure. | il/km | d the daath. Do | 1412 E. | drass of Facility B. SCRUGG PRESTON lying, such as cardiac | ST BA | LTO, MD | | |
| | Physician /Medical Examiner | Immediata Causa (Final disaasa or condition rasulting in death) | aCOCAIN | NE AND N | ARCOTIC IN | TOXICATION | | | Onsat and Double | |
| | <u>.</u> | | | Dua to (or as a | consaquanca of): | | | | | |
| 90, | cate be executed physician and sthe burial-transit | Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury | f . | Dua to (or as a | consequence of): | | | -13.17 | | |
| Box 68760, | E 00 5 | rasulting in death) Last | d | Dua lo (or as a | consaquanca of): | - 3-0. | | | | |
| P.O. | that the sed by the detache | | litions contributing to death t | out not resulting i | n the underlying ceuse | 23b. Dld 1 | ntribute to the cause of death? | | | |
| Records, | aw requi | | | | | | 24a. Was perfo | an autopsy rmed? | 24b. Wara autopsy tindings available prior to complation of cause of daath? | |
| al H | ician: The li certificate he rector, page | | 1 № Yas 2 □ No 1 1 🗷 Yas 2 □ | | | | | | | |
| of Vital | | 1 TYTES 2 No | Hospital: | ant 200 ER/O | utpatient 3 DOA | 26. Piaca ot Dea Othar: 4 ☐ Nursing H | oma 5□ Rasio | | ar (Specify) | |
| | Attending Phy or death actor: After this by the funeral of iffcation: T | | ading FCUTTO. De stigation 1-20-20 | ay Year) 28b. | Tima of 28c. Injury | njury at Vork? □ Yas 22 YNo | | unknown | | |
| Division | tai or as after as Direct | 3 ☐ Suicide XX Coldat dat | old not be 28a. Place of In | jury - At homa, fa | rm, straat, factory, offic | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1706 BETHEL ST. BALTIMORE, MD | | | |
| | Hospi 24 hou Funer stely fill | 29a. Cartifier 1 ☐ Certifier (Check only 2 ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ | ying Physician: To the best at Examiner: On the basis of and mannar st | of axamination an | | | | | | |
| | To the comple | 29b. Signatura and titla of cer | ifier | 1 | | nsa number O.C.M.E. | | 29d. Data signa JANUAR | d (Month, Day, Year) XY 21, 2000 | |

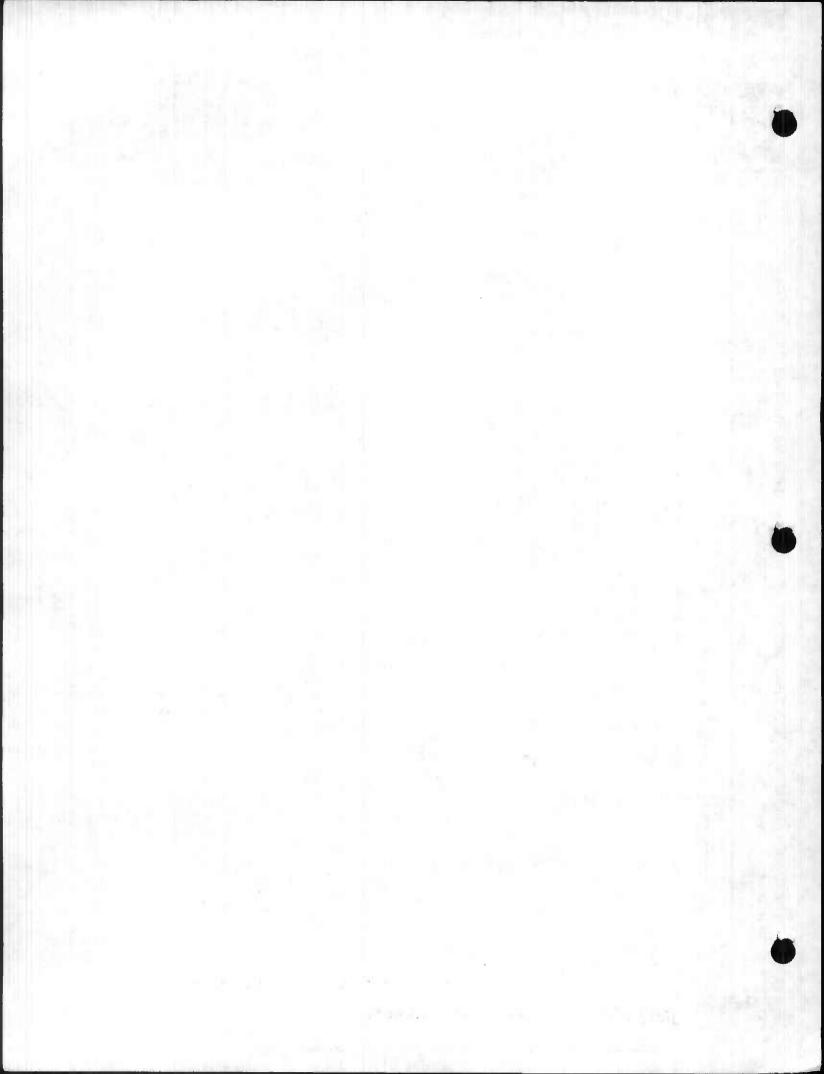
30. Nama and address of person who complated causa of death (Nem 23a) (Type, Print)

Stroken 5. Nadentz, 111 Penn Street, Baltimore, Maryland 21201 Stephen 5. Radentz 111
31. Data filed (Month, Day, Year)
JAN 3 1 2000

Server 32. Registrar's Signatura

DHMH 16 Rev 6/95

Registrar



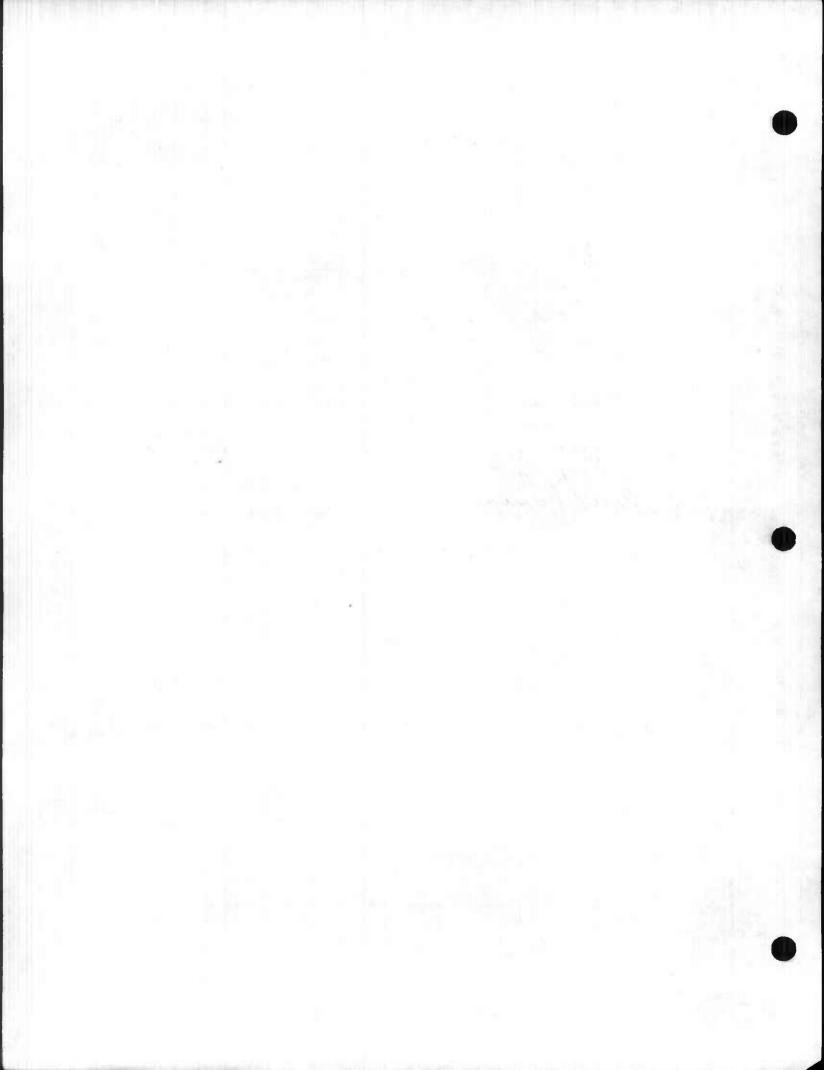
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

State

Registrar

DHMH 16 Ray 6/95

Lyen



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle Last) 2 Date of Death 3 Time of Death January 25, 2000 1:35 A.M. William F. McDade, Jr. 4b. City, Town, or Location of Death 4e Facility Name (If not institution, give street and number) 4c. County of Death Crofton Convalescent Center Crofton Anne Arundel 5. Social Security Number 6. Sex → M 2□ F If Under 1 Year If Under 24 Hrs. 8. Dele of Birth (Month, Day, Year) May 17 19: 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months Days Hours Min. 578 34 9175 70 Yrs 1929 Mississippi Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes ZONo Maryland Anne Arundel Crofton 10e. Street and Number 10g. Citizan of What Country? 10f. Zip Code 1570 Crofton Parkway 21114 United States 12. Wes Decedent Ever in U,S. Armed Forces?

1 ☑ Yes 2 ☐ No If Yes, Give Yeer or Dates: 51-53 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Meritel Status 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No Specify Specify. 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Assistant Director G.S.A. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) William F. McDade, Sr. Agnes Grayson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William McDade, III Son 533 Park Road Severna Park Maryland 21116 20b. Place of Disposition (Name of cemetery, cremetory or other place)

January 28, 2000 ocation - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veterans Cemetery Crownsville Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Fecility Robert E. Evans Funeral Home, Inc. 21. Signelyre of Fundal Service Licansee 16000 Annapolis Rd. Bowie Maryland 20715 23a. Part1. Enter the disease, or complications to a used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset end Deeth Immediata Causa (Final disease or condition rasulting in death) Atheros clerotic Heart Distance eminal Multiple Myeloma y

Due to (or as a consequence of):

eminal Multiple Myeloma y

Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Lesl Due to (or as e consequence of): 23b. Did tobacco use contribute to the cause of death? Part ti, Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 1 YSS 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 25. Was case referred to medical examiner? 28. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Natural
2 Accidant 5 Pending Investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 281. Location (Street end Number or Rural Route Number, City or Town, State) 28a. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

P.O. Box 68760,

Physician

· /Medical

Examiner

Directo

Funeral

þ

Completed

2

Examiner

Physician/Medical

by

Completed

P

Certification:

edicai

29a. Certifier

(Check only one)

29b. Signeture end little of certifier

Funeral

Director

7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Madical Examiner inset be notified at

2 should be filled within 72 hours after death v and Mental Hygiena. Is marked other than "natural", or items 234

permit. Pagas 1 and 2 sh Department of Health and Important: If Item 27 Ie m any Injury or other traum once.

Physician

/Medical

Examiner

physician and the burial-transit

ed pinous

Baltimore, Maryland 21215-0020

tha Maryland

certificata be executed Division of Vital Records. Attending

aftar death To the Hospital within 24 hours a To the Funeral D

death.

Registrar

anora, MD

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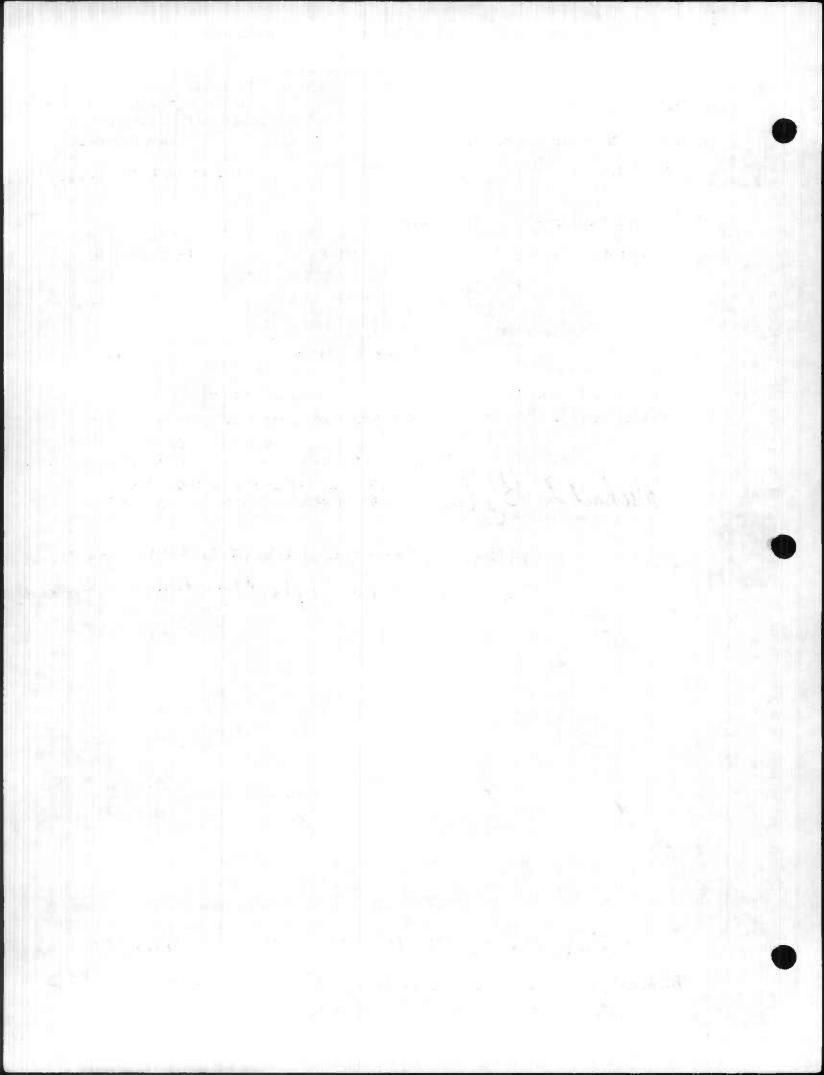
Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated.

Medical Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Dete signed (Month, Day, Year)

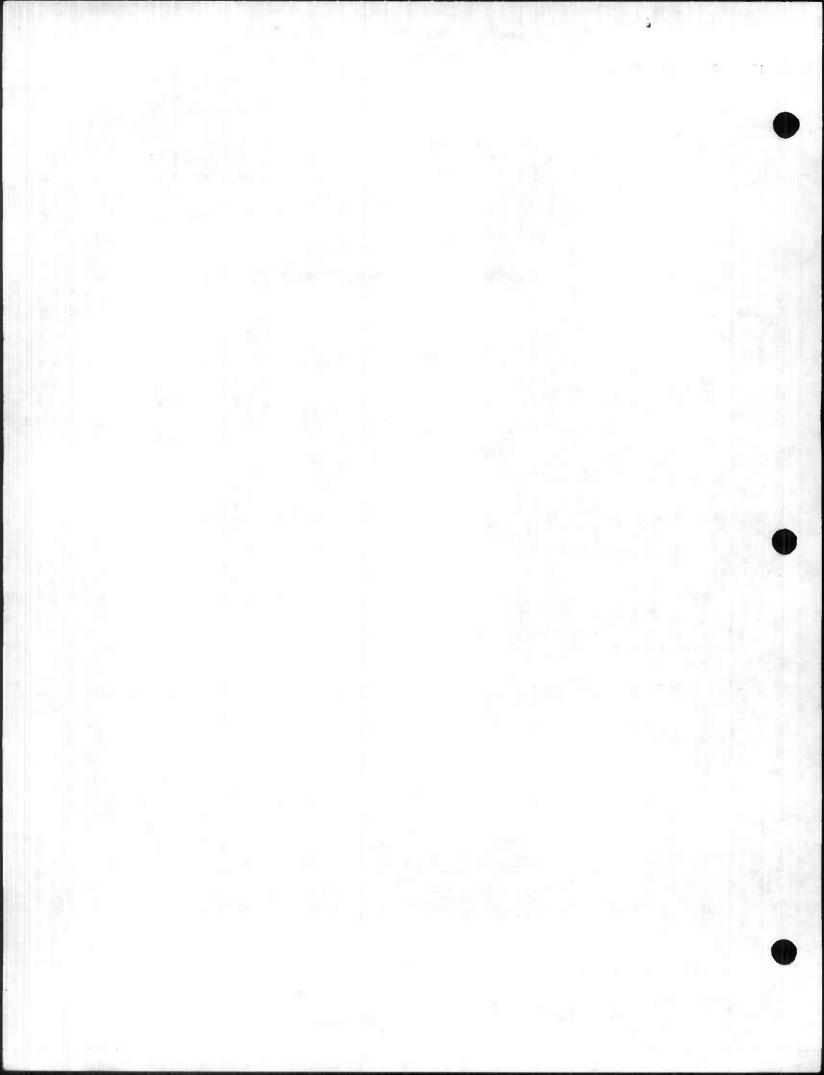
30. Nama and address of person who complated causa of daeth (Itam 23e) (Type, Print)

14300 Gallant Fox Lane Fowie mos 32. Registrar's Signature

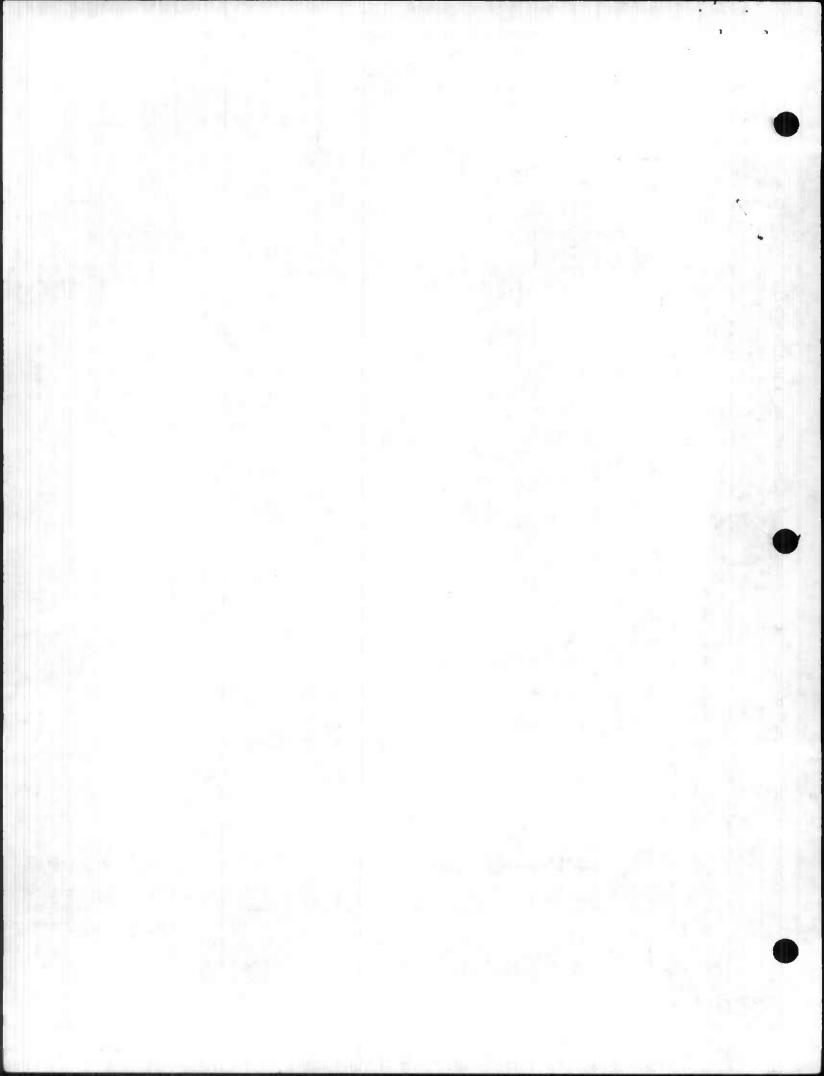


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|-------|---|---|-------|
| State | of Maryland / Department of Health and Mental Hygiene | n | 02171 |
| AH | Cortificate of Dooth | U | 0611 |

| ENDED ITEMS #7,8 | PER FH G779 1/31/2000 AH | Certificate of Death | Reg. No. | | | | | | |
|--|--|--|---|--|--|--|--|--|--|
| Physician | 1. Decedent's Neme (First, Middle, Last) Patricia C. Meyer | 2. Dete of Death Month Day Year Anuaru 20, 2000 3:45 P. M | | | | | | | |
| /Medical Examiner | 4a Facility Name (If not institution, give street and number) St. Mary'S County No | cation of Death dc. County of Death Hown St. Mary S | | | | | | | |
| Funeral Director | | lest birthdey) If Under 1 Yeer If Under 24 Hra. Montha Days Hours Min. | 8. Date of Birth 2/24/47 9. Birthplace (State or Foreign (Month, Day, 7647) 9. Birthplace (State or Foreign Country) WOShim ton D. | | | | | | |
| vith the Maryland or 28a-f ehow or rottred at | | ity, Town or Location 21 Kers VIIIe | 10d. Inside City Limits 1 ☐ Yes 2 10 No | | | | | | |
| 23a th w | 100. Street and Number 8631 Discovery Blvd. | 101. Zip Code 21793 | 10g. Citizen of What Country? USA | | | | | | |
| 5 2 2 3 | 11. Meritel Stetus 1 Never Merried 2 Merried 3 Widowed 4 Divorced 12. Wes Decedent Ever in the Armed Forces? 1 Yes 2 No If Yes, Give Yeer or Dates: | J.S. 13. Was Decedent of Hispanic Origin? (Speif Yes, specify Cuban, Mexican, Puerto | cify Yes or No- Rican, etc.) 14. Rece - American Indien, Bieck, White, etc. Specify: White | | | | | | |
| Baltimore, Maryland 21215-0020 semit. Peges 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or his may injury or other traumatic event, the Medical Examina ansa. To Be Completed by Fur | 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) | 16a. Decedent's Usual Occupation (Give kind of work done during most of work) life. DO NOT use retired) BOOKKEEPET | Building Construction | | | | | | |
| faryland 2 2 should be filed and Mental Hygi le marked other summatic event, To Be Co | 17. Father's Name (First, Middle, Last) Robert B. Wagner | 18. Mother's Name | (First, Middle, Melden Sumame) L INEZ TYLET | | | | | | |
| Marylcand 2 should alth and Mer 27 is marke or treumatic | 19e. Informent's Name/Relationship (Type, Print) GODTIELLE T. Fry | 19b. Meiling Address (Street end Number or Rura 120-12 Willow Da | 1 Route Number, City or Town, State, Zip Code) le Dr. Frederick, MD 21702 | | | | | | |
| Box 68760, asth certificate be assected attending physician and for use as the burial-transit clary. Aedical Examiner | 23a. Pert1. Enter the disease, or complications that caused the deashook, or heart failure. List only one cause on each tine. Immediate Cause (Final disease) or condition resulting in death) Sequentially list conditiona, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury) Cause (Disease or Injury) | or as a consequence of): | Gift Foundation Ave. Laurel, MD 20101 respiratory errest, Approximate Interval Between Onset and Deeth Onset and Deeth 23b. Did tobacco use contribute to the cause of death? | | | | | | |
| Division of Vital Records, P.O. or atterdesh. I or Attending Physician: The law requires that the darter desh. The properties has been signed by the funeral director, page 2 should be detected with the funeral director, page 2 should be detected ertification: To Be Completed by Physician properties. | | 1 Yee 2 No 3 Probably 4 Unknown 24e. Was an autopsy performed? 24b. Wera autopsy tindings aveilable prior to completion of cause of death? | | | | | | | |
| The law requin | | of death? | | | | | | | |
| Vision of Vital Is attending Physician: The sector: After this certificate by the funeral director, page tification: To Be Co | 25. Was case reterred to medicat examiner? 1 Yas 2 No 27. Manner of Death 1 Naturat 5 Pending 28a. Date of Injury (Month, Day Year) | | ne 5 Residence 6 Other (Specify) 28d. Describe how injury occurred | | | | | | |
| Division c Hospital or Attending P 124 hours after dealth. Detail precion: After t bletely filled in by the funeral edical Certification: | 2 Accident investigation 3 Suicide 6 Could not be determined 8. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 286. Place of Injury - At home, farm, street, factory, offica City or Town, Stete) | | | | | | | | |
| | 29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, dete end piece, and due to the cause(s) and manner as stated. Medical Examiner: On the best of my knowledge, death occurred at the time, dete end piece, and due to the cause(s) and manner as stated. Medical Examiner: On the best of my knowledge, death occurred at the time, dete end piece, and due to the cause(s) and manner as stated. Medical Examiner: On the best of my knowledge, death occurred at the time, dete end piece, and due to the cause(s) and manner as stated. | | | | | | | | |
| To weight | 29b. Signeture and fittle of certifier 30. Name and address of person who completed cause of deeth (Ite | 29c. License number 29c. License number D 06 4 (| 29d. Date signed (Month, Day, Year) | | | | | | |
| Con | James P. Jarboe MD /24035 3 31. Dete filed (Month, Day, Year) 32. Registrar's Sign | Knotch Rd. Hollywo | od, MD 20636 | | | | | | |
| State Registrar | JAN 3 1 2000 | B. Spark | | | | | | | |



| tem 238 | | me (First, Middla, Las | | er Columb | Certificate of | Death | 2. Date of Dea | | | 3. Time of Death |
|--|--|---|---|---|--|---|--|--|-------------------------------|--|
| Physician /Medical | | istopher | Moffe | | | | JANUAF | RY 20, 2 | Year 2000 | 1400 PM |
| Examiner | 4a Facility Name 1508 EL | (If not institution, give LWOOD AVEN | street and number) | OND FLO | OOR | 4b. City, Town, or Li BALTIMOR | | 4c. County | | |
| | 5. Social Security | √n '' | 9X 7. As | ge (In yrs. last bi | irthday) If Under 1 Year Months Days | | 8. Date of Birth (Month, Day 02-03 | h y, Year) | 9. Birthplac | e (Stata or Foreign |
| red at | Usuat Residence 10a. State M D | 10b. County NA | | | wn or Location | | | | 10d. | . Inside City Limits NOWas 2 □ No |
| al Direc | 10e. Street and N 1508 E. | umber 11wood St | treet | | 10f. Zip Code 2121. | 3 | | 10g. Citizan of V USA | Vhat Country | 7 |
| þ | 3 ☐¥Widowed | rried 2 Married | 12. Was Decedent Armed Forces? XXYes 2 If Yes, Give Yaar or Dates: | | 13. Was Decedent of If Yes, specify Cub | | ecity Yes or No- Rican, etc.) | 14. Raci Blac Specify | a - American k, White, etc | |
| ompleted | (Spot | | ucation de completed) College (1-4or NA | | a. Decedent's Usual Occu (Giva kind of work dona lifa. DO NOT use ratire Car Wash | pation during most of work ad) | | 16b. Kind of Bu | | |
| To Be Co | Colum | o (First, Middle, Last) | Moffe | | | 18. Mother's Nam | e (First, Middla, | Maiden Surnam | stewa | ert |
| | Carl 20a. Method of Di | | wart | 20b. Place of cemata | b. Mailing Addrass (Stree 104 Darle) of Disposition (Nama of ary, cramatory or other ple 1ell Mem. (| y Avenue | Balti | more, 20c. Location - | Maryl City or Town | and |
| | as colonial | uneral Service Licent | / | 1 | | - ' | 7. * | 14 | vland | 1 21202 |
| E E B | 19 | linin, | K.(/) | an | | rch FH l | 101 E. | North | Aven | nue |
| cian lical iner | 19 | the disease, or comp and failure. List only o | otications that sause ona causa on each li | IC INTO | | rch FH l | 101 E. | North | Aven | |
| an call ner | 23a. Part1. Enter shock, or he immediata Causa disease or condit | the disease, or compart failure. List only of a (Final ion) conditions, immadiata derlying or injury its | otications that sause ona causa on each li | IC INTO | WM.C.Ma | rch FH l | 101 E. | North | Aven | DUC pproximate itarval Between |
| ached for use as the burial-transit ached for use as the burial-transit bysician/Medical Examiner | 23a. Part1. Enter shock, or he immediata Cause disease or condit resulting in death Sequentially list of any, leading to cause. Enter Uncause (Disease othat initiated aver resulting in death | the disease, or compart failure. List only of a (Final ion) conditions, immadiata serying or injury its) Last | b | IC INTO Due to (or as a Due to (or as a | WM . C . Ma o not enter the mode of dy XICATION a consequenca of): | rch FH 1 | 101 E. or respiratory ar | North | Aven | pproximate ntarval Between onset and Death |
| Medical Xaminer 1.5 Ineral Inector Description of the principal of the pr | 23a. Part1. Enter shock, or he immediata Cause disease or condit resulting in death Sequentially list of any, leading to cause. Enter Uncause (Disease othat initiated aver resulting in death | the disease, or compart failure. List only of a (Final ion) conditions, immadiata serying or injury its) Last | b | IC INTO Due to (or as a Due to (or as a | WM.C.Ma: o not enter the mode of dy XICATION a consequenca of): a consequenca of): | rch FH 1 | 23b. Did t | North rest, tobacco use con Yes 2 No an autopsy med? | Aven | pproximate atarval Between onset and Death onset and Death on the cause of death? bly 45 onknown a autopsy findings able prior to oletion of cause ath? |
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| rs after death. The first confiction has been signed by the attending physician and in portant: If tem 27 is marked other than "natural", or items 23 or 28-4 show a factor of the innertal director, page 2 should be detached for use as the bunal-transit and in price of the funeral director, page 2 should be detached for use as the bunal-transit and in price of the funeral director and the function of the funeral director and the function of the fu | 23a. Part1. Enter shock, or he immediata Cause disease or condit resulting in death Sequentially list of any, leading to cause. Enter Uncause (Disease or that initiated aver resulting in death Part II. Other sign 25. Was case referexaminer? PCXYes 2[27. Manner of Det 1 | a (Final conditions, immadiata derlying or injury its) Last arred to medical nvestigation of Could not be datarmined | b | Due to (or as a Due to (or as a | WM.C.Ma: onot enter the mode of dy XICATION a consequenca of): consequenca of): in the undarlying cause given the undarlying | ivan in Part I. 26. Ptace of Deather: 4 Nursing Holy at tok? Yes 2 No | 23b. Did to 1 24a. Was performent to 1 28d. Describe to 1 28d. Describ | North rest, Robacco use con Yes 2 No an autopsy med? Yes 2 No ona) dence 6 Oth how injury occur on, Stata 150 Inc. Md causa(s) and ma | Aven | poproximate iterval Between onset and Death onset and Death onset and Death onset and Death onset and Death? bly 4 onknown a autopsy findings able prior to pletton of cause ath? Yes 2 No Routa Number, Cllwood Average |

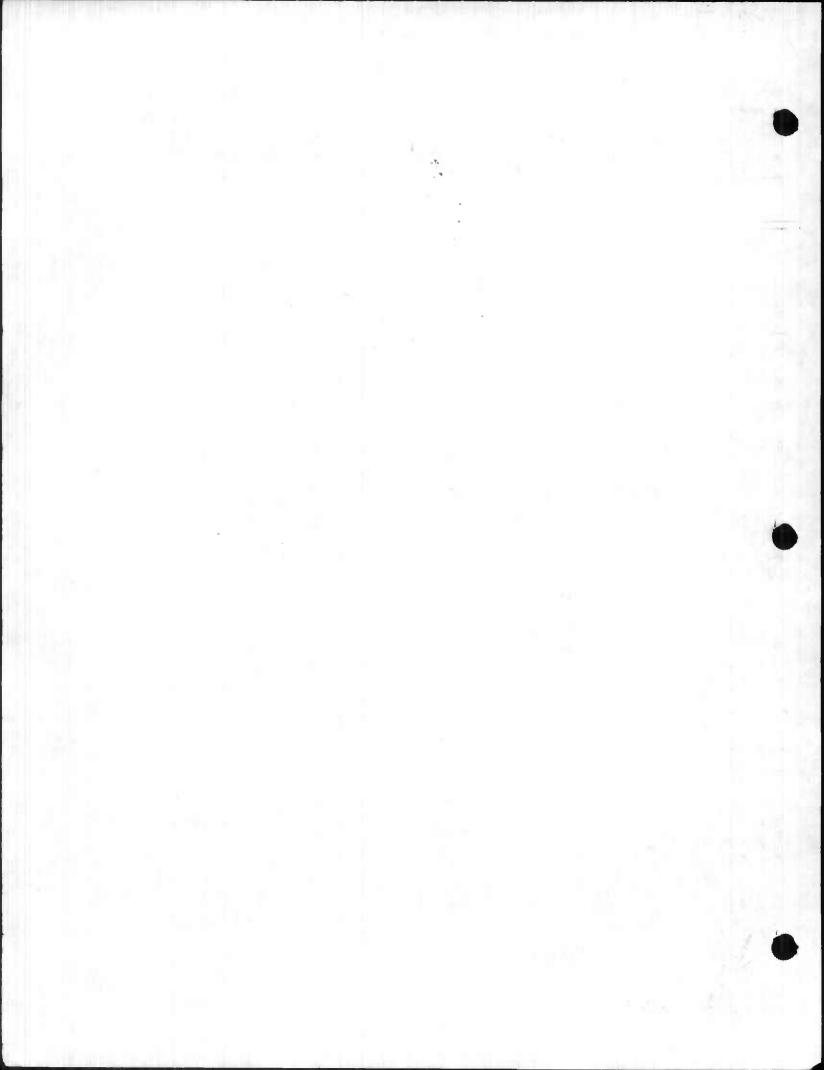


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** January 25, 2000 Isabele Palubis 12:30 PM /Medical 4b. City, Town, or Location of Daath 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Ellicott City Howard Saint Agnes Nursing & Rehab Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 02/21/21/ 7. Aga (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foraign Country) **Funeral** 1 M 2 PF Lithuania 213-30-1619 87 Yrs. Director Usual Residence of Decedent with the Marylend permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylen Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or itema 23a or 28a-f ahow any injury or other traumatic avent, the Medical Examination and be notified an once. 10a. Stata 10b. County 10c. City, Town or Location 10d, fnsida City Limits N/A Baltimore 1 Yes 2 No Maryland Directo 10g. Cifizen of What Country? 10e. Streef and Number 10f. Zip Code United States of America 21229 419 Westgate Road Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Evar in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 11. Marifal Sfatus 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: Baltimore, Maryland 21215-0020 Specify: White þ 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Collega (1-4or 5+) Millenary Housewife Domestic 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Fafhar's Name (First, Middle, Last) Zemaityte Kezenius Marijona Pranas 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 419 Westgate Road Baltimore, Maryland 21229 Juozas Palubis / Husband 20b. Piece of Disposition (Name of cematery, crematory or other piece) 20c. Location - City or Town, State 20a. Method of Disposition 1 Buriai 2 ☐ Cremation 3 ☐ Removal from Stata 01/29 Baltimore Maryland Louden Park Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signafure of Funeral Service Licensee 22. Name and Addrass of Facility Weber CFSP David J. Weber Funeral Homes, P.A. Kathlean 5311 Edmondson Ave. Baltimore, Maryland 21229 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** disase /Medical Immediate Cause (Final disease or condition resulting in deeth) (Broncery Cesterie **Examiner** Examiner 000 The law requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Disease or injury that Initiated events resulting in deeth) Last to (or as a consequence of): Box 68760. Physician/Medical Dua to (or as a consequence of) P.O. Part fl. Other significant conditions contributing to death but not rasulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 20 No 3 Probably 4 Unknown Division of Vital Records. þ 24b. Were autopsy tindings available prior to completion of causa of death? page 2 should Completed 24e. Was an eutopsy performed? After this certificate has 1 Yes 2 No No 1 ☐ Yes 2 ☐ No Physician: Be 25. Was cese referred to medicei 26. Piece of Death (Check only one) Hospitel: 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 427 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28d. Describe how Injury occurred 28c. Injury at Work? al or Attending P after deeth.

I Director: After to in by the funera 5 Pending investigation 1 Naturai 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Routa Number, City or Town, State) Tathe Funeral Directo 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and plece, end due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and plece, and due to the cause(s) and manner stated. Medical 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and theyof certifier 29c. Licensa number MI of person who completed ceuse of deeth (Item 23e) (Type, Print) M. Zuniga MD 1101 maiden choice Lane Baltimore 21209 duis 31. Date Hied (Month, Day, Year) 32. Regisfrar's Signature State Registrar sparke

ORIGINAL



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Death 2. Dete of Deeth Month 28th 2000 Per1 Rosa an 4b. City, Town, or Location of Death 4c. County of Death 4e Fecility Name (If not institution, giva street end number) The Hebrew Home of Greater Washington Rockville 5. Social Security Number 6. Sax 7. Age (In yrs. last birthday) 1 Under 1 Year 1 Under 24 Hrs. (Month, Dey, Year) 7. Age (In yrs. last birthday) 1 Under 1 Year 1 Hours | Min. (Month, Dey, Year) Montgomery Birthplece (Stete or Foreign Country) 1 M 200 Yes 566-58-9975 9.2 Dec. 29,1907 Poland Usuei Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits XXYes 2 No Maryland Montgomery Rockville 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 6121 Montrose Rd. 20852 United States 14. Rece - Amarican Indian, Bieck, White, etc. 12. Wes Decedant Evar in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 11. Maritei Status 1 Yes 2 No If Yes, Give Yeer or Datas: 1 Never Married 2 Merried 1 Yes 2X No Specify: Specity: 3 ☑ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Coilege (1-4or 5+) Importer/Exporter 12 Cosmetics 17. Fether's Neme (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Sumame) Samuel Schreiber Breinder Tillis 19e. Informent's Neme/Reletionship (Type, Print) 19b. Melling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jacob Stempel/Son 2 Watchwater Way Rockville, MD. 20850 20b. Plece of Disposition (Neme of cemetary, cramatory or other plece) 20c. Location - City or Town, Stete 20e. Method of Disposition 1. Bunal 2 Crametion 3 Removel from State Judean Memorial 1/30 Olney, MD. 22. Neme and Addrass of Facility Stein Hebrew Funeral Home. 232 Carroll St. NW Washington, DC. 20012 Keel Fartt. Enture disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrast, shock, or want fellure. List only one cause on each line. Onsat and Death Immediata Causa (Final diseasa or condition resulting in deeth) Cardio burnownind Dua to (or es a consequence of): Coronary Due to (or es e consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initiated events Dua to (or as a consequanca of): resulting in deeth) Lest Part II. Other significant conditions contributing to death but not resulting in the undarlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown 24b. Wara autopsy findings available prior to completion of ceusa of deeth? 24a. Wes en eutopsy performed? Sitrontea OStroporo 515 Constinutions 1 Yes 2 No 1 ☐ Yes 2 ☐ No 26. Place of Deeth (Check only one) Chronic Cerebral 25. Wes case referred to medical exeminer? Hospitei: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Dey Year) 27. Menner of Deeth 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending Investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Steta) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicida

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permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oths any Injury or other traumatic evant, phose.

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Certifying Physician: To the best of my knowledge, death occurred et the time, date end piece, and due to tha causa(s) and mannar es statad.

2 Medicat Examiner: On the basis of examinetion and/or invastigetion, in my opinion, daeth occurred et tha time, data end place, and due to the ceuse(s) end menner steted.

29c. License number

29d. Date signed (Month, Dey, Year)

30. Name and address of person who completed cause of death (Itam 23a) (Type, Print) Consulta

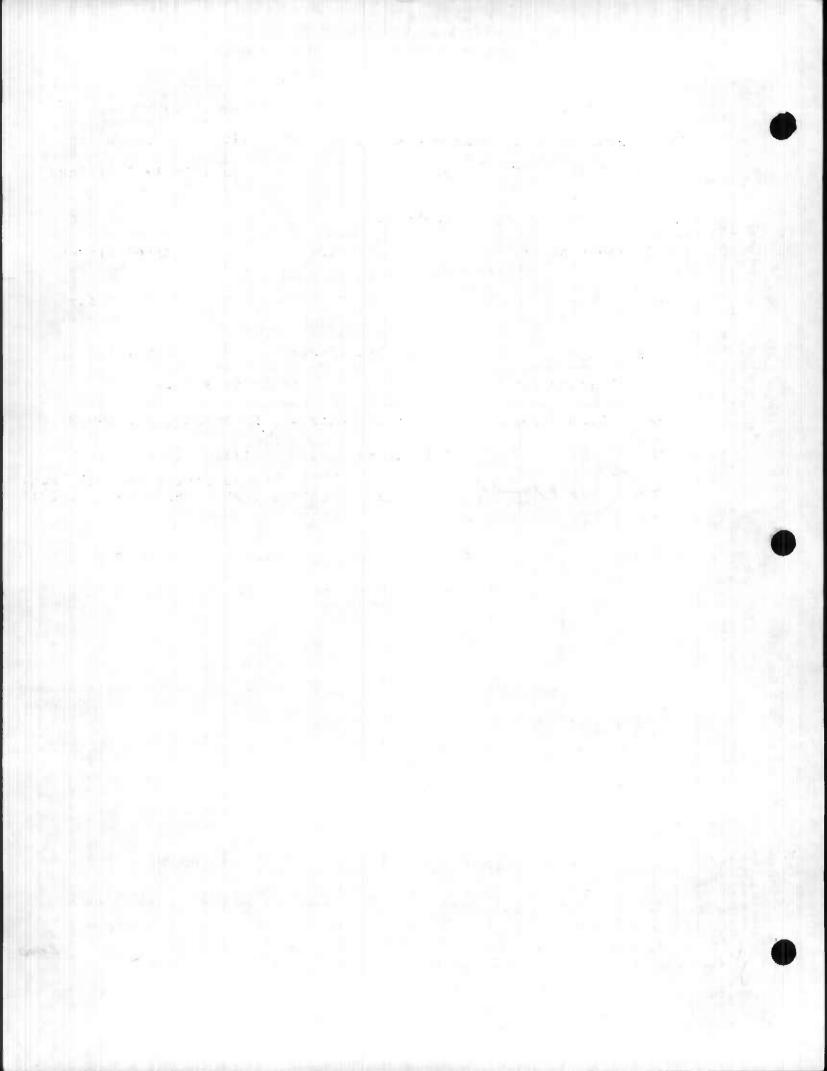
Road Rocknile my JAN 3 1 2000 32. Registrer's Signeture

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(Check only one)

29b. Signeture end title of certifier

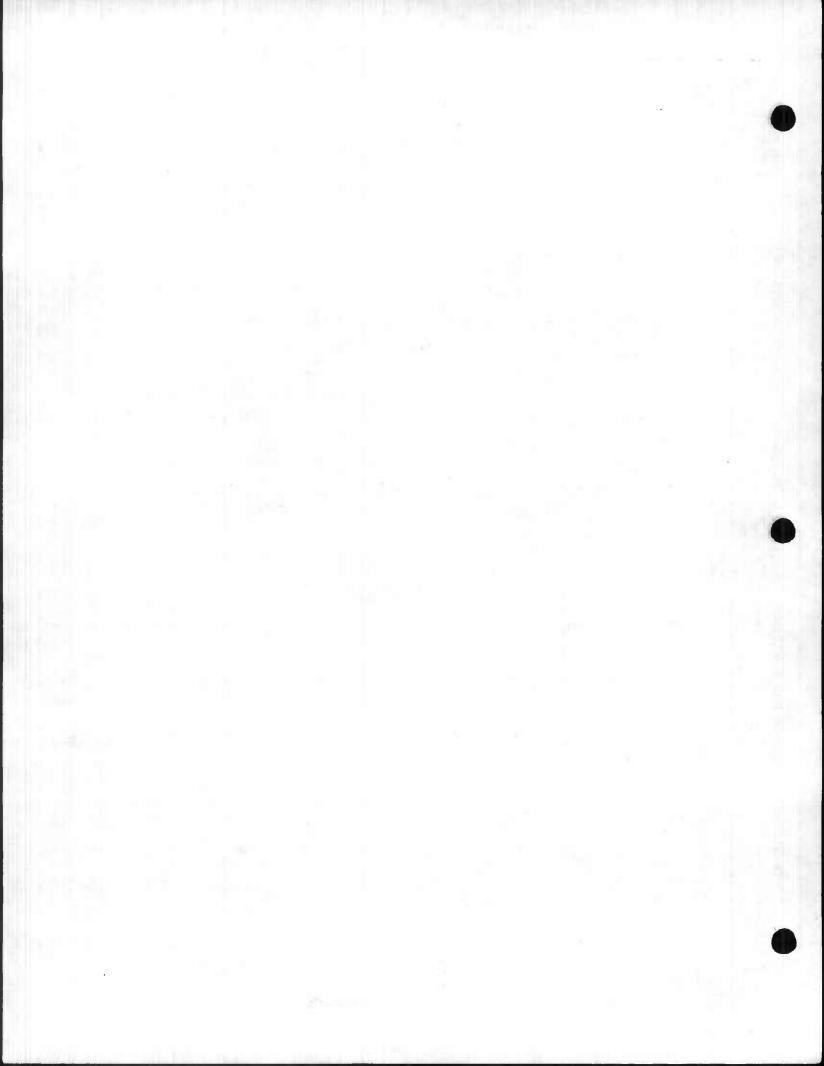
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMENDED ITEM #7 PER FH G779 1/31/2000 AH Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month **Physician** Reitenbach Valentin 4b. City, Town, or Location of Death d doar 2000 /Medical 4a Facility Name (If not institution, give street end number) 4c. County of Death Adventist 7. Age (In yrs. last birthdly) If Under 1 Ye 90 Q1 Yrs. Months Da ROCKULLE

If Under 24 Hrs. 8. Date of Birth
(Month, Day, Montgomery Small Grove 9. Birthplace Votate or Foreign Country)
BOSNIC 5. Social Security Number If Under 1 Year 6. Sex 1 M 2 □ F **Funeral** Days -7833 Director -30 May 1. Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits worde Montgomery 1 Yes 2 No Director MD Haomery 288-1 10e. Street and Number 10f. Zip-Code 10g. Citizen of Whet Country? ò U.S. A Koga 20886 234 12. Wes Decedent Ever in U,S. Armed Forces?
1 ☐ Yes 2 ☐ No Herma Was Decedent of Hispanic Origin? (Specify Yes or No-tl Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Meritel Stetus Black, White, etc. e filed within 72 hours efferal Hygiene.
other than "natural", or the 1 Never Married 2 Merried altimore, Maryland 21215-0020 1□ Yes 2 No If Yes, Give Year or Dates: Specify: White 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Etementary/Secondary (0-12) College (1-4or 5+) Engineer Forestry permit. Pages 1 and 2 should be file.
Department of Health and Mental Hyp, important: if item 27 is marked other any injury or other traument. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Reitenback Elizabeth 10 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19400 Transhire Rd Montgomery VI lage, MD 20886 branka 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremetion 3 Removal from State
Donation 5 Other (Specify) Anatomic 61ft Foundation 1/24/00 Laurel MD ure of Funeral S 13948 Baltimore Avenue 22. Name and Address of Facility Laurel MB 20707 Anatomic 61ft Foundation and. Enter the disease or complications that ceused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, look, or heart failure. List only one cause on each line. Approximate Intervat Between Onset and Death **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical / Luchdas Examiner Due to (or as a consequence of): Examiner Musicidism that the deeth certificete be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Box 68760 Physician/Medical Due to (or es e consequence of) P.O. | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown signed i Records, à 24b. Were eutopsy findings evailable prior to Completed 24e. Was an autopsy performed? completion of cause of deeth? 6 bressicu 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: Be 25. Wes cese referred to medical examiner? 26. Place of Death (Check only one) Hospitat: Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Naturel 5 Pending death. 1 Yes 2 No Investigation 2 Accident after death Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital or A within 24 hours after To the Funerel Directompletely filled in by 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture and fitte of certifier COU. 12/11/02 anugra 5000 30. Name and address of person who completed ceuse of death (ttem 23a) (Type, Print) C. Forn 95 11805 29 Docter. 1 2000 31. Date filed (Month, 32. Reofstrar's Signature State Registrar



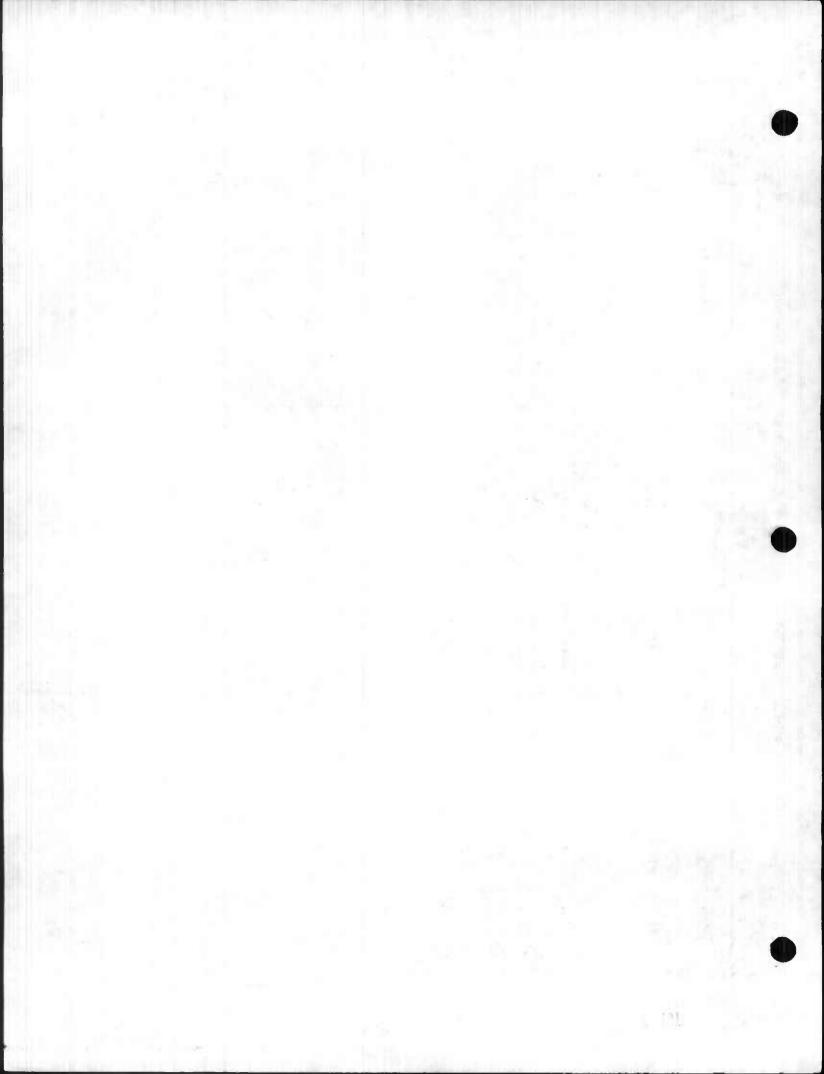
State of Maryland / Department of Health and Mental Hygiene

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| Di | 1. Decedent's Name (First, Middle, L. | | | | | | 2. Date of Death Month Dey | | Year | 3. Time of Death | | |
| Physician /Medical | Chester Michael | | | | | | JAN. | 25, 2000 | | 2249 PM | | |
| Examiner | 4a Facility Name (If not institution, gr MERCY MEDICAL | 184 | 4b. City, Town, or Location BALTIMORE | | | | | | | | | |
| uneral irector | 219-18-0117 | Sex 7. Age (III | Titigo (myto: act omerody) | | | 24 Hrs. Min. | 8. Date of Bir (Month, Da July 9 | th 9. Birthplac (Country), 1927 Mary | | place (State or Foreign ntry) yland | | |
| Health and Mantal Hygiene. tem 27 is marked other than "natural", or itema 23s or 28s-f show other traumstic event, the Medical Examiner must be notified at other traumstic event, the Medical Examiner must be notified at other forms. To Be Completed by Funeral Director | Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Maryland N/A Baltimore | | | | | | | | 10d. | | | |
| | 10e. Street and Number 10f. Zip Code | | | | | | | | 10g. Citizen of What Country? | | | |
| | 130 E. Gittings S | 21 | 230 | | | | USA | | | | | |
| | 3 ☐ Widowed 4 ☑ Divorced | 12. Wes Decedent Eve Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates: ₩₩ | If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☑ No. Specify: | | | 14. Rece - American Indian, Black, White, etc. Specify: White | | | | | | |
| | 15. Decedent's E (Specify only highest gr | 16a. Dec | 16a, Decedent's Usuel Occupation | | | | | 16b. Kind of E | | | | |
| | Elementary/Secondary (0-12) | College (1-4or 5+) | | (Give kind of work done during most of work life. DO NOT use retired) Merchant Marine | | | | | | General Contract Construction | | |
| | | 0 | | | | 18. Mother's Name (First, Mid | | e (First, Middle | ddle, Maiden Sumame) | | | |
| | | owski | | | | Mary | y Der | mski | | | | |
| is man | 19a. Informant's Name/Relationship | (Type, Print) | 19b. Ma | iling Addres | s (Street | end Numb | er or Run | lural Route Number, City or Town, State, Zip Code) | | | | |
| om 27 iu | Frank Rakowski/Sc | n | 194 | 5 Wal | dhei | n Rd. | Hel: | lertown | ,PA. 18 | 055 | | |
| important: If them 27 any injury or other the ence. | 20a. Method of Disposition 1 ☐ Buriel 2 ☑ Cremetion 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci | _Inemoval from State (| | f Disposition (Name of ny, cremetory or other place) Ount Crematory 02/01/00 Baltimor | | | | | | re, Maryland | | |
| Important: If it any injury or once. | 21. Signature of Funeral Service Lies | nsee // | | David | J. | ess of Facili | Fune | eral Ho | mes, P. ore,Mar | A. | 21221 | |
| | 23a. Part1. Enter the disease of conshock, or heart failure. List only | men | | 401 5 | . CII | ester | SL. | Dartin | ore, mar | утапо | Approximate Interval Between | |
| ding physician and see as the burial-transit | | С | | as a consequence of): | | | | | | | | |
| M M | | | | | | | | | | | | |
| by the | Pert II. Other significant conditions | | | | | | | 23b. Did tobacco use contribute to the cause | | | V | |
| b & d | | | | | | | | 24a. Was an autopsy 24b. Were eutopsy f | | | | |
| 76 Z | | | - | | h | | | | uctin | ev cc of | relieble prior to ompletion of cause death? | |
| # 0 e | 25. Was case referred to medicel | | | | | 26. Place | e of Deat | h (Check only | one) | | И | |
| | examiner? XX Yes 2 □ No | Hospital: 1 ☐ Inpatient | 2O€R/Outpati | ent 3 D | OA OI | hor: | | | | her (Speci | fy) | |
| ctor: After this y tha funaral of fication: T | 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation | 28a. Date of Injury (Month, Day Ye | 1 Inpatient 200EH/Outpatient 3 DOA | | | 4 U Nursing Home 5 U Hes | | | be how injury occurred | | | |
| ctor: y tha | 3 Suicide 6 Could not a determined | 28e. Place of injury | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) | | | | | |
| al te | 29a. Certifier 1 Certifying P | hyaician: To the bast of m miner: On the basis of exa and manner stated | amination and/or i | ath occurred investigation | d at the ti n, in my | me, date ar opinion, dea | nd place, ath occurr | and due to the red at the time, | cause(s) and m | nanner as a , and due t | stated. o the ceuse(s) | |
| To the Furcompletal | 29b. Signeture end title of certifier | and marmer stated | | 29 | c. Licen | se number | | | 29d. Date sign | ed (Month, | Day, Year) | |
| | > Theolis | M. Kens | 3 ms | | | C.M.E | 3 | | | 26, 2 | | |
| 1 | 30. Name and address of person who | | | | reet | , Bal | timo | re, Mar | yland 2 | 21201 | | |
| State | 31. Date filed (Month, Day, Year) | 32! Registrar's | | | | | | | | | | |
| Registrar | IAN 2 1 2000 | he had | 6 1 | | | | | | | | | |

DHMH 16 Rev 6/95

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year Reagar Margaret 7.6141 Com 24 Januar 2000 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Ballinge Johns Hopkins Hospital If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Months Days Hours 1 M 2CKF 92 Yrs. 218-36-7634 MARYLAND **Usual Residence of Decede** 10e State 10b. County 10c. City, Town or Location 10d Inside City Limits YXYes 2 No MD. N/A BALTIMORE 10e Street and Number 10f. Zip Code 10g, Citizen of What Country? 2813 EASTERN AVENUE 21224 .S.A. 12. Was Decedent Ever in U,S. Armed Forces?, 1 Yes 2 2 100 If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: 3XXWidowed 4 □ Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) DOMESTIC 8 HOUSEWIFE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) JOSEPH DOCKAL ZAMRZLA MARY 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2641 EASTERN AVENUE, BALTIMORE, MARYLAND 21224 GEORGE REAGAN/ SON 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 1/26/00 | BALTIMORE, MARYLAND GREENMOUNT CEMETERY 21. Signature of Funeral Service Licenses 22. Name and Address of Facility LILLY & ZEILER INC. FUNFRAL HOMF 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21231 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Renal Failu 2265 Due to (or as a consequence of): Frelenie Colo 3 madel 25 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 3 weaks performed Durcheral Wice Due to (or as a consequence of): Itip Fracture Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy nerformed? 1 Yes 2 No 1 Tyes 2 No

26. Place of Deeth (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

281. Location (Street and Number or Rural Route Number, City or Town, Stete)

29d. Date signed (Month, Day, Year)

Baltinsie, MD

24,2000

Physician /Medical Examiner

Department o Important: If any injury or

Physician

/Medical

Examiner

Director

Funeral

p

Completed

Be

Funeral

Director

must be notifie

or harns

al Hygiene, natural', or harra voori, the Medical Examiner,

Pages 1 and 2 should be filed within 72 hours ether varied Health and Mental Hyghen.
Intil filem 37 is merked other then "natural; or its uny or other traumatic event, the Medical Examinas

Baltimore, Maryland 21215-0020

Box 68760,

P.O.

Division of Vital Records.

The Maryland

Examiner Physician/Medical à Completed 80

physician and s the buriel-transit or Attending Physician: The lew requires that the deeth certificate be axecuted T USA 08 1 signed by the a d be detached f pege 2 has certificata funeral director, Certification: To the After 24 hours efter deeth. 3

25. Was case referred to medical 1 Yes 2 No 27. Manner of Death 1 Natural 2 Accident 3 ☐ Suicide 4 Homicide

29a. Certifier

(Check only one)

29b. Signature and title of certified

Medical To the Hosp within 24 hou To the Fune complately fi

filled in

Hospital

State Registrar

DHMH 16 Rev 6/95

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David J. Caparallinio 31. Date filed (Month, Day, Year) JAN 3 1 2000

5 Pending investigation

6 Could not be determined

32. Registrar's Signature Dancera

28a. Date of Injury (Month, Day Year)

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Surgical House Office

Goo M. Wolfe Street Johns Hopkins Hospital

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

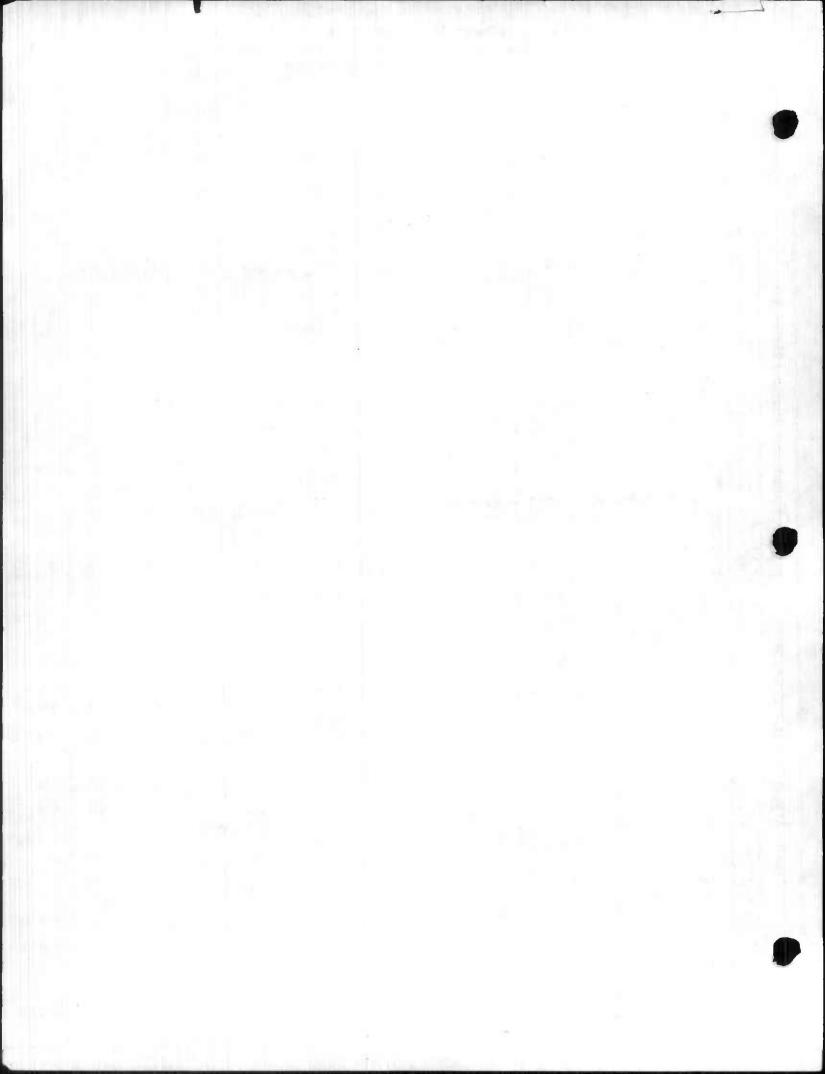
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

1 Yes 2 No

Res-200

ORIGINAL

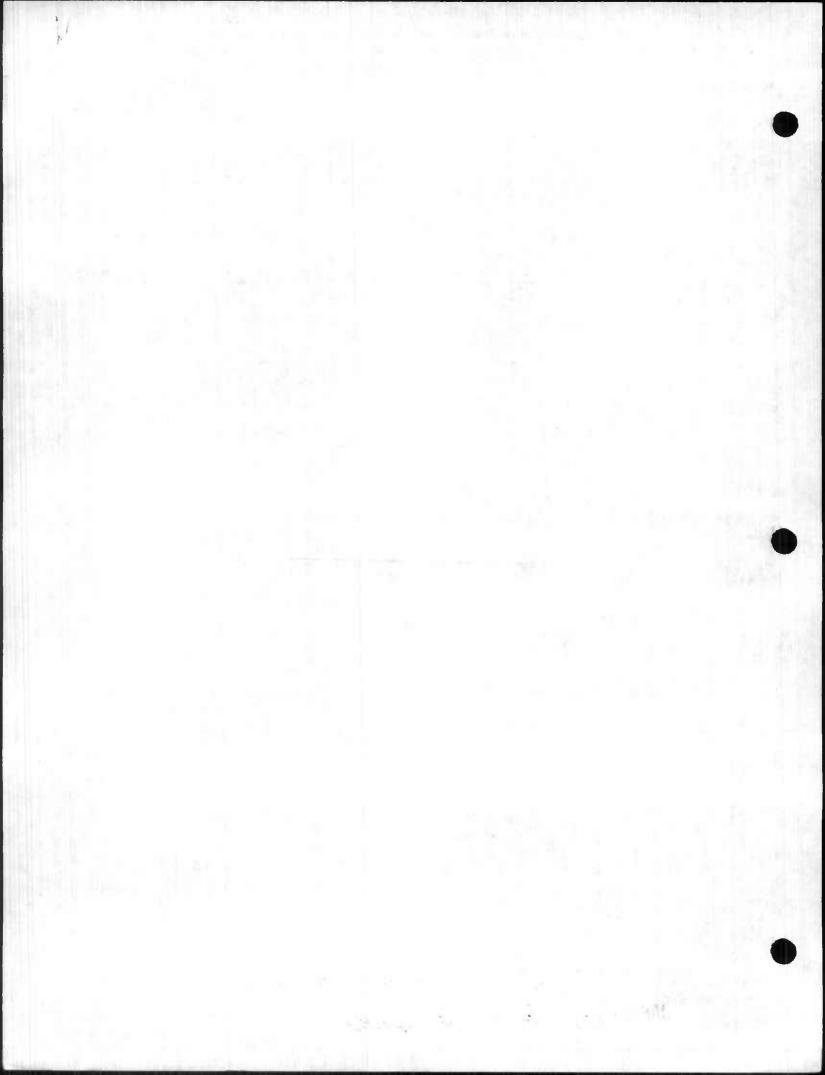


Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

| AMEND Physicia | 1. Decedent's Name (First, Middle, Last) | | 2. [| Reg. No. Data of Death Month Day | Year 3. Tima of Death | | | |
|--|---|--|--|---|--|--|--|--|
| /Medica Examine | Fatima Kanm | an | 4b. City, Town, or Location BALTIMORE | JANUARY 27, | 2000 0307 AM inty of Death | | | |
| • Funeral Director | 5. Social Security Number 6. Sex 1 M 2 X F 56 Usual Residence of Decedent | ast birthday) If Under 1 Yea Months Days | If Under 24 Hrs. 8. p | Date of Birth Month, Day, Year) 9-27-1943 | Birthplece (State or Foreign Country) Md | | | |
| show at at | 10a. State 10b. County 10c. City | /, Town or Location | | | 10d. fnside City Limits 1 ☑ Yes 2 ☐ No | | | |
| with the N t or 28a-f be notifi | 10e. Streel and Number | altimore 10f. Zip Code | | | of What Country? | | | |
| 5-0020 72 hours after death with the Maryss natural; or leans 23s or 25s-f sho disal Examiner must be notified at | 3820 Reisterstown Road 11. Marital Status 12. Was Decedent Ever In U; Armed Forces? 1 Never Married 2 Married 3 Widowed 4 Divorced 1 Yes, Give Year or Dates: | 21215 S. 13. Was Decedent of If Yes, specify Cul | Hispanic Origin? (Specify pan, Mexican, Puerto Rica | n, etc.) B | A lace - American Indian, llack, White, etc. | | | |
| Maryland 21215-9020 2 should be fined within 72 hours all th and Menial Hygiene. 7 is marked other than "setural", or traumatic event, the Medical Evant | 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) N/A College (1-4or 5+) N/A | 16a. Decedent's Usual Occi (Give kind of work done life. DO NOT use refin Laborer | during most of working | Chime | Business/Industry s Industry ng Center | | | |
| /land | 17. Father's Name <i>(First, Middle, Last)</i> Abdur Rahman | | 18. Mother's Name (Fir Rasheeda | cst, Middle, Maiden Sume Crawford | ame) | | | |
| Mary 2 shox 12 shox 1s mar | 19a. Informant's Name/Relationship (Type, Print) | 19b. Meiling Address (Street | | | | | | |
| L. Pages 1 and treent of Health Sant if then 27 qury or other is | 1 US Surial 2 Li Cremation 3 Li Hemoval from State | 2202 Wheatle lece of Disposition (Name of emetery, crematory or other plants Memorial Par | ace) | 102 Baltim 20c. Location 20c. Location | ore, Md 21207 n-City or Town, State | | | |
| Balti pemit. Departm imports eny inju | 21. Signature of Funeral Service Licensee | 22. Name and Addi | | | | | | |
| - in a | Immediate Cause (Final disease or condition resulting in death) Due to (or if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | SORDER AND DIA ras a consequenca of): ras a consequenca of): as a consequence of): | ABETIC KETOA | CIDOSIS | | | | |
| death ce | Part II. Other significant conditions contributing to death but not resu | ulting in the underlying cause g | iven in Part f. | 23b. Did tobacco uss | contribute to the cause of death? | | | |
| is, r.C. 500 | SCHIZOPHRAMIO | SCHIZOPHRAMIO | | | | | | |
| aw requir | Part II. Other significant conditions contributing to death but not result. SCHIZO PHROM D | | | 24e. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? | | | |
| VITAL H | | | | 1⊿Yes 2□No | Nerves 2□ No | | | |
| Of VITA Physician: this certific | | ER/Outpatient 3□ DOA O | 26. Place of Deeth (Charles) ther: 4 T Nursing Home | | Other (Specify) | | | |
| To the Hospital or Attending Physician: The I within 24 hours after death. To the Eigneral Director: After this certificate he completely filled in by the funeral director, page | | 28b. Time of 28c. fnj | | Describe how injury occ | Residence 8 □Other (Specify) ibe how injury occurred | | | |
| LIVISION C tal or Attending P is after death. all Director: After t led in by the funers | 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At ho building, etc. (Specif) | me, farm, street, factory, office ') | 281. | Location (Street and Nu City or Town, State) | mber or Rural Route Number, | | | |
| To the Hospital within 24 hours Forthe Euneral Completely filled | 29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my know consideration on the basis of examinat and manner stated. | wledge, death occurred at the lon and/or investigation, in my | ime, date and place, and opinion, death occurred e | due to the cause(s) and the time, date and plac | manner as stated. ca, and due to the ceuse(s) | | | |
| To the within within to the to | 29b. Signature and fittle of certifier Multiple Melliple M | | C.M.E. | | ned (Month, Day, Year) RY 28, 2000 | | | |
| MIN | 11121091 | Penn Street, | Baltimore, M | Maryland 21 | 201 | | | |
| State Registra | 31. Date filed (Month, Day, Year) 32. Registrar's Signal | lure | | | | | | |

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nema (First, Middla, Last) 2. Data of Deeth 3. Time of Death Mary Agnes Smith 2000 24. 10:00 A.M. January 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, giva street end number) 5226 Benson Ave. Arbutus Baltimore If Under 1 Yaar If Undar 24 Hrs. 5. Social Security Number Birthplaca (Stata or Foraign Country) 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) 1₽M 2□F Months Days Hours Min. 97 215 76 1286 Yrs. Sept. 15, 1902 Baltimore MD Usuel Rasidance of Decedent 10a Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 ☐ Yas ŽĚ No Maryland Baltimore Arbutus 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 21227 United States 5226 Benson Ave. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 22 No If Yas, Giva Yaar or Detas: Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuben, Mexican, Puerto Rican, atc.) 14. Race - American Indian Bleck, Whita, atc. 1 Nevar Married 2 Married 1 Yas ⊉QNo Specify: Specify: White 3€Widowed 4 Divorced 16a. Dacedant's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Specify only highast grada completed) 18b. Kind of Business/Industry Elementary/Secondary (0-12) Cotlega (1-4or 5+) Homemaker Own Home 16. Mother's Nama (First, Middle, Maiden Sumama) 17. Fathar's Nama (First, Middla, Last) Frank Reid Isaac Naamah Champagne 19a. Informant's Name/Ratationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 14271 Cedar Lane Greensboro Maryland 21639 Stanley D. Smith, Jr. Son 20b. Place of Disposition (Nama of camatery, cramatory or other placa)
Jan. 27, Date 000
20c. Location - City or Town, Stata 20a. Mathod of Disposition 1 ☐ Buriel 2 ☐ Cremation 3 ☐ Ramoval from Stata Hillcrest Memorial Cemetery Annapolis Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signatura of Funeral Sarvice Licanse 22. Nama and Addrass of Facility Robert E. Evans Funeral Home, Inc. Robert E. Evans runeral and 20715

16000 Annapolis Rd. Bowie Maryland 20715

Approximate Interval Batwaen Onset end Death 23a. Part1. Entar tha disaasa, or complication 10 t caused tha daath. Do not anta shock, or haert failura. List only ona cell on each line. Immadiata Causa (Final disease or condition resulting in death) 21 atol Dua to (or as a consequenca of): hudiation Sequentially list conditions, if any, laading to immediate cause. Entar Undarlying Cause (Disaase or Injury that initiated avants rasulting in daath) Last Dua to (or as a consequence of) trolyte 00 Due to (or as e consequanca of): 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

Physician /Medical Examiner

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Physician

/Medical

Examiner

Directo

Funeral

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Completed

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Funeral

Director

r than "natural", or items 23s or the Medical Examiner must be

Baltimore, Maryland 21215-0020

filled within

Hygiene.

permit. Pages 1 and 2 should be fill.
Department of Health and Mental Hy
Important: If Nem 27 is marked oth
any injury or other traumatic even

Examiner physician and the burial-transit 98 signed by the e i certificate has b

thet the deeth certificete be executed Division of Vital Records, P.O. Box 68760, Physician/Medicai þ Completed Hospital or Attending Physician: Be 2 this funeral Certification: After death. after death Director: To the Hospital or Attenwithin 24 hours after dea To the Funeral Director completely filled in by th

Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. Wara autopsy findings avaitable prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 1 ☐ Yas 2 ☐ No 25. Was casa referred to medical axaminer? 26. Placa of Death (Check only ona) Othar: 4 Nursing Home 5 Rasidence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mennar of Death 28e. Dete of Injury (Month, Day Year) 28d. Dascribe how Injury occurred 28b Time of 28c. Injury at Work? 1 Natural 2 Accident 5 Pending 1 Yas 2 No Invastigation 6 Could not be datarmined 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Pleca of Injury - At homa, farm, streat, factory, office building, etc. (Specify) 4 Homicide 12 Certifying Physician: To the best of my knowledge, deeth occurred et the time, data end piece, and due to the causa(s) and mannar as stated.

2 Medical Examiner: On the best of examinetion and/or investigetion, in my opinion, deeth occurred at the time, data and place, and due to the cause(s) and manner stated. 29a, Certifier

State Registrar

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31. Data filad (Mont)

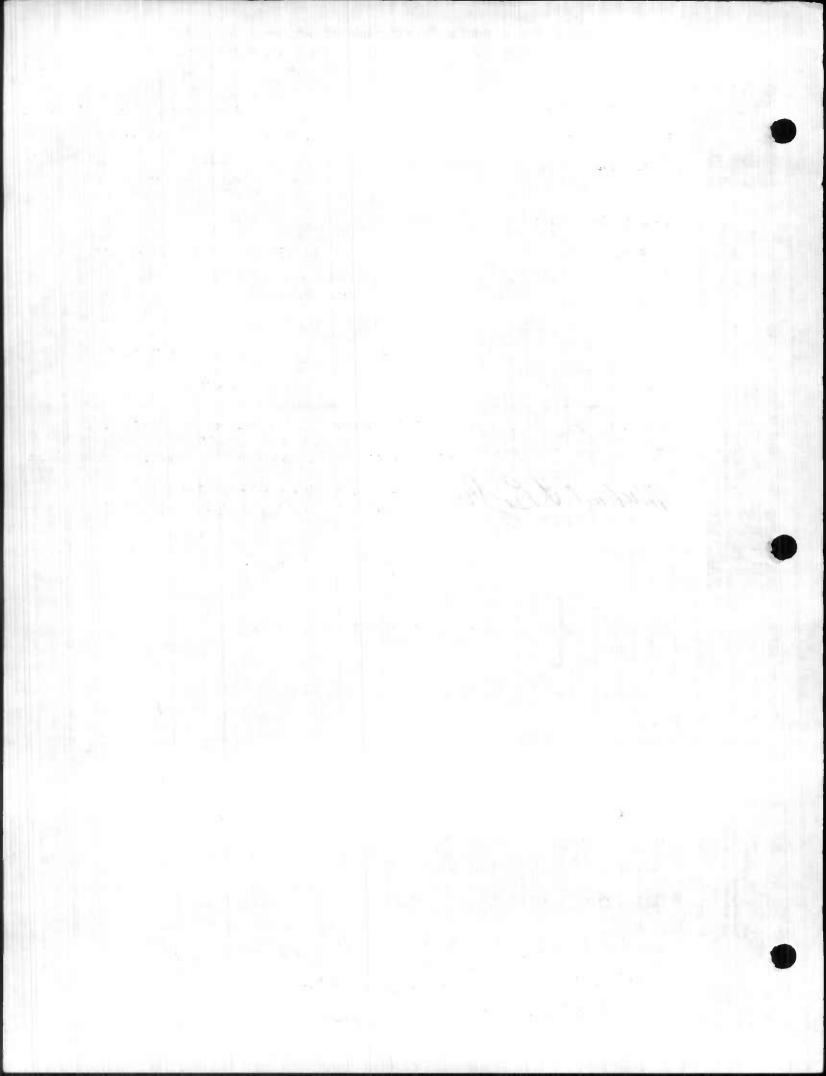
29b. Signatura and title of certifian

W 32. Registrar's Signetura

ass of person who completed cause of death (Itam 23a) (Type, Print)

29c. Licansa number

29d. Date signed (Month, Day, Year)



Please Type or Print in Black indelible ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) Frank Sanes 2. Dete of Deeth 3. Time of Death Month 25, 2000 7:40pm January 4b. City. Town, or Location of Deeth 4e Facility Neme (If not institution, give street and number)
Prince George Community Hospital 4c. County of Death Cheverly | H Undar 1 Yaer | H Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthpiacs (State of Month) | Dec. 15, 1916 | Arkansas 5. Social Security Number 431-66-5405 7. Age (In yrs. lest birthdey) 9. Birthpiaca (Stata or Foraign XXM 2 F Yrs I Isuai Basidance of Dacedent 10a. Sfala 10b. County 10c. City, Town or Location 10d. Inside City Limits **Blytheville** 1 ☐ Yaa 2 ☐ No Arkansas 10g. Citizen of Whet Country? 10e. Street and Number 10f. Zip Coda 72315 1001 Gean Street 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Detas: Wes Decedenl of Hispenic Origin? (Specify Yas or No-If Yas, specify Cuben, Mexican, Puerto Rican, atc.) 14. Race - American Indien, Bleck, White, etc. Black 11. Marifai Status 1 Never Merried 2 Married 1 Yes 2 No 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry Elementery/Secondary (0-12) 12th Grade College (1-4or 5+) Self-Employed Farmer 18 Mother's Name (First, Middla, Meidan Sumema) Annie Whimper 17. Father's Neme (First, Middle, Last)
Frank Sane, Sr. 19e. informent's Name/Reletionship (Type, Print)
Marie Huddleston 19b Mailing Address (Street and Number or Rural Route Number City or Town, State Zip Code) 802 Converse Avenue East St. Louis, Illinois 62201 daughter 20b. Place of Disposition (Name of cametery, cremetory or other place)
Gethsemane Cemetery 20c. Location - City or Town, Steta 20a. Method of Disposition 1 Surial 2 Crametion 3 Removel from Stete Blytheville, Arkansas 4 □ Donetion 5 □ Other (Specify) 22. Name end Address of Fecility Nutter Funeral Homes, Inc. 21. Signalure of Funerel Sarvice Licenses 2501 Gwynns Falls PKWY Baltimore, Md. 21216 23e. Pert1. Enter the diseesa, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on aech line. Approximata Intarvat Between Onset end Death immedieta Cause (Finel diseasa or condition resulting in deeth) Cancer 04 Sequantially list conditions, if any, laading to immadiate cause. Entar Underlying Ceuse (Disaase or injury that initiated evants rasulting in daath) Last Due to (or es e consequence of): Pert it. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings avelleble prior to completion of cause of death? 24a. Was en autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical axeminar? 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Homa 5 Rasidenca 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatiant 2 ☐ ER/Outpetient 3 ☐ DOA 28d. Describe how injury occurred 27. Menner of Deeth 28e. Date of Injury (Month, Dey Year) 28c. Injury et Work? 5 Panding investigation 1 DeMatural 1 TYes 2 □ No 2 Accident 6 Could not be datermined 28f. Location (Street and Number or Rural Routa Number, City or Town, Stete)

Physician /Medical Examiner Physician/Medical Examiner

Physician

/Medical

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Funeral

Director

28a-f show

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Completed

item 27 is marked other than "naturel", or items 23s or 28s-f show other traumstic event, the Medical Examiner must be notified at

Injury or

any it

permit. Pages 1 and 2 should be filed within 72 hours efter death with to Department of Heelth and Mentel Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 2

Baltimore, Maryland 21215-0020

the Maryland

attending physician and for use as the buriel-transit the signed by the peen : certificate has

by

Completed

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Certification:

edicai

The law requires that the deeth certificete be executed Division of Vital Records, P.O. Box 68760, or Attending Physician: 24 hours after deeth.

Funeral Director: After this letely filled in by the funeral di

Hospital To the F within 2

29b. Signeture and title of certifier

3 Suicide

29e. Certifier

4 - Homicida

(Check only one)

29c. License number

1 Certifying Physicien: To the best of my knowledge, deeth occurred et the time, date end place, and dua to tha causa(s) and mannar as stated.

2 Medical Examiner: On the basis of examinetion end/or invastigation, in my opinion, death occurred et the time, deta end place, end due to the cause(s) end manner stated.

29d. Dete signed (Month, Dey, Year)

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2000

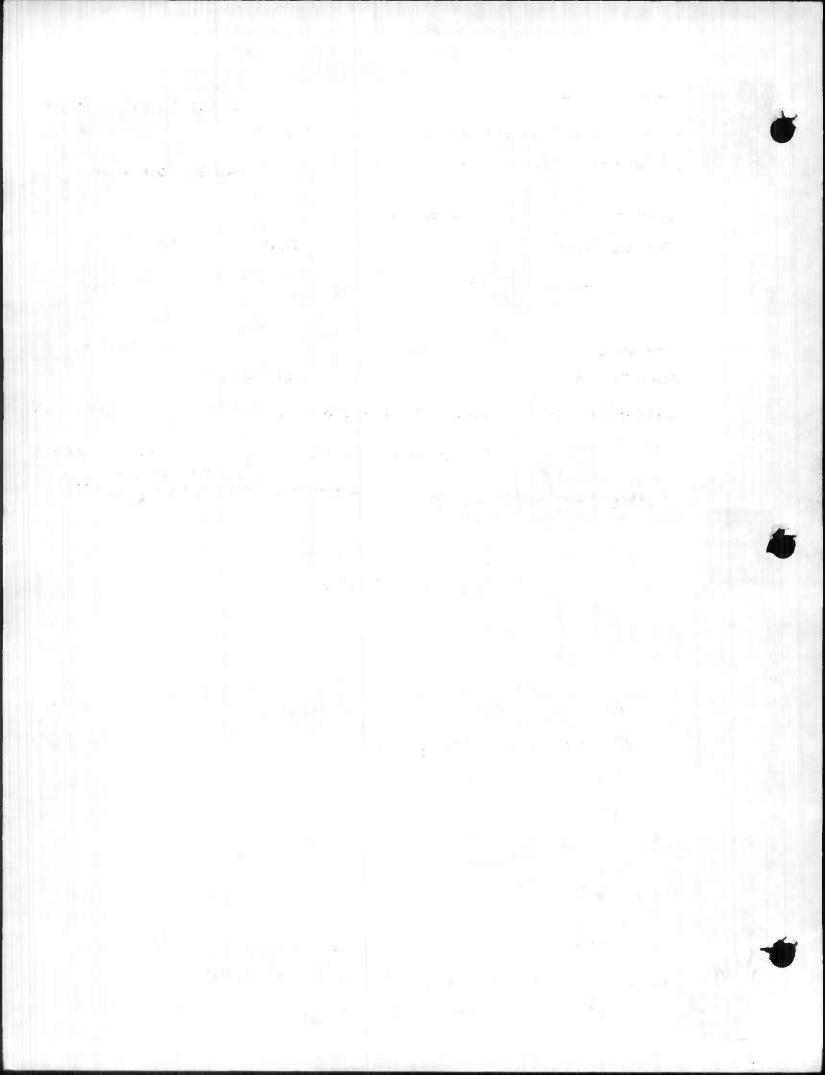
30. Nama and eddress of person who complated cause of daeth (Item 23a) (Type, Print)

3001 Cheverly Host Brit 32. Registrer's Signeture

Deperson

28e. Pleca of Injury - At home, ferm, street, fectory, offica building, atc. (Specify)

Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death . Month 3. Time of Death **Physician** Tewes 00 No 4b. City, Town, or Location of Death 27 /Medical pm 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Ballimore GT ohns 100 PI 201 NIUC 0 If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day. 5. Social Security Number Sax 2DF 7. Age (In yrs. last birthday) **Funeral** Days Yrs. ALABAMA 69 Director 214-26-2439 Jan. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X es 2 □ No Director BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 Berns 23s 106 N. MILTON AVENUE 21224 U.S.A. Funeral 12. Was Depedent Ever in U.S. Armed Forces? 1.0 Yes. 2 □ No If Yes. Give Year or Dates: 1948-51 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be liked within 72 hours after of Department of Health and Mental Hygiens. Important: If Nem 27 is marked other than "natural", or Nes any Injury or other traumetic event, the Medical Example 1 Never Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 Ø No Specify: p 3 ☐ Widowed 4 ☐ Divorced white Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 9 MERCHANT MARINE SEAMAN 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) HUGH LEVELLE STEWART MARY ELIZABETH CLEMENT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 106 N. MILTON AVENUE, BALTIMORE, MARYLAND 21224 JOANNA STEWART/WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial XXCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GREENMOUNT CEMETERY 1/29/00 BALTIMORE, MARYLAND 21. Signature of Funeral Service Licensee ZEILER INC. FUNERAL HOME & 1901 EASTERN AVENUE, BALTIMORE, MARYLAND 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of): Physician/Medical Examiner mans 33 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): certificate be exe P.O. Box 68760. Schemu g Due to (or as a consequence of): The law requires that the death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, Be Completed 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 1 TVen 280 No 1 Ves 2M No certificate Division of Vital Hospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this certifica 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4□ Nursing Home 5□ Residence 6 □Other (Specify) 1 Yes 252 No 1 Empatient Certification: To 2 □ ER/Outpatient 3 □ DOA 27. Manger of Death Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 (3Natural 1 Yes 2 No 2 Accident 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) AG SE 4 Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and place, and due to the cause(s) and manner as stated. (Check only 2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the to comple 29c. License number 29d. Date signed (Month, Day, Year) Many 30. Name and address of payson who completed cause of deeth (Item 23a) (Type, Print) FOLDMAN LIFFUED GOD N.

Registrar
DHMH 16 Rev 6/95

State

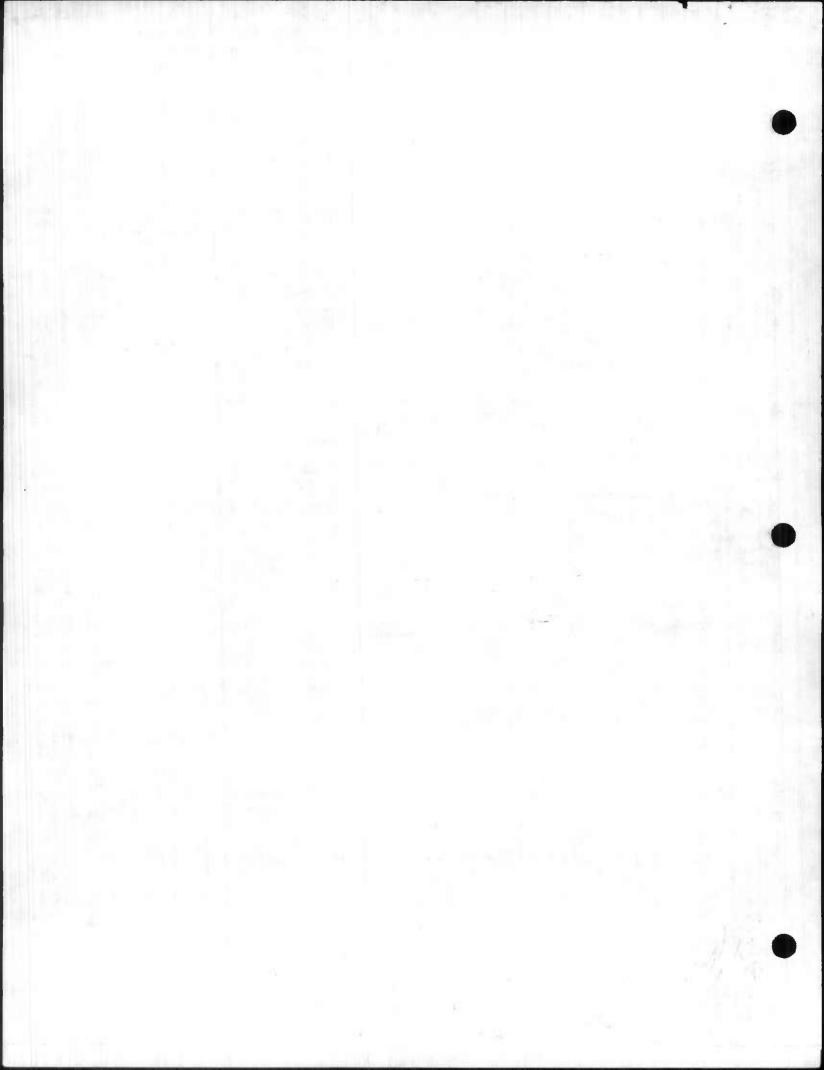
31. Date filed (Month, Day, Year)

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girl and on.

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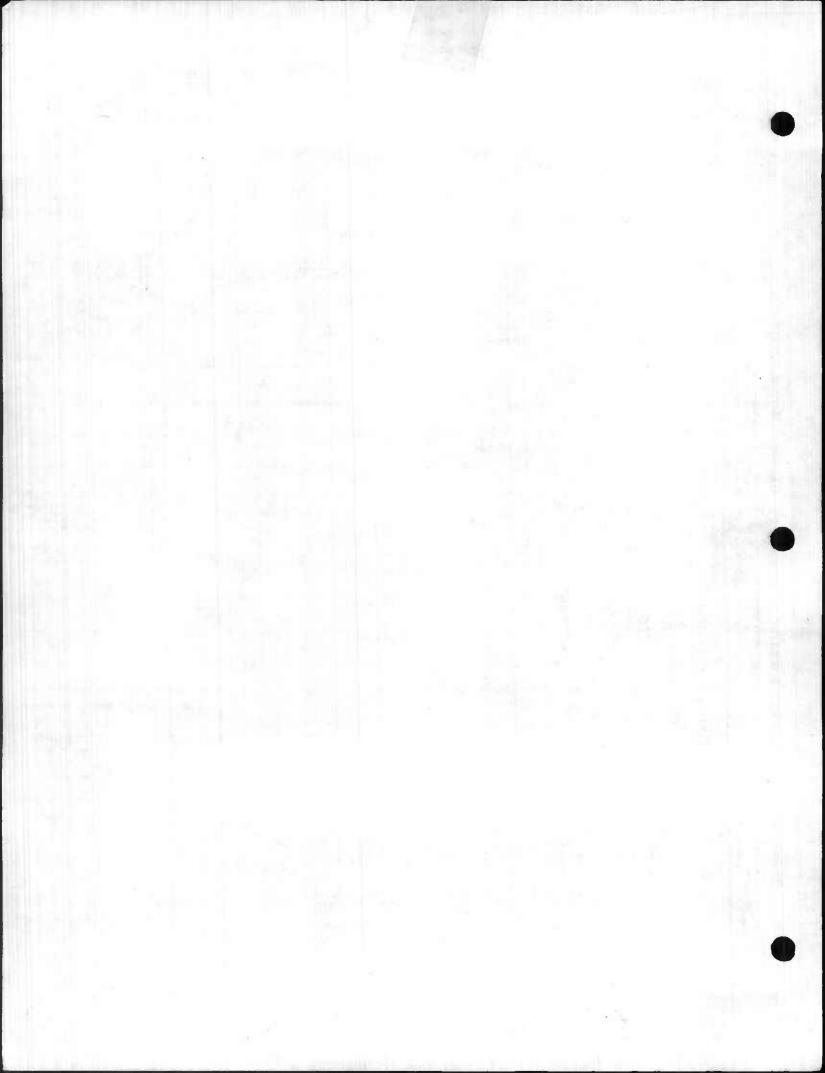
32. Registrar's Signature



| | | | | Cert | ificate of | Death | | Reg. No. | | 02100 |
|--|---|--|--------------------------------------|--|--|--|--|--|--------------|--|
| hysician | 1. Decedent's Name (First, Middle, | | | | | | 2. Date of Do Month | Day | Year | 3. Time of Death |
| /Medical | Max Mende | | | | | | Janua | | 2000 | 12:45A1 |
| Examiner | 4a Facility Name (If not institution, | 10 |) | | | 4b. City, Town, or | Location of Deal | th 4c. Count | y of Death | |
| | Suburban Hos | - | | | If Under 1 Year | Bethes | | Mon | tgome | |
| neral ector | | 3. Sex 7. Ag | 8 5 | est birthday) Yrs. | Months Days | Hours Min | . (Month, D. | nn ay, Year) 18,191 | h | lace (Stete or Foreign try) omania |
| 10 | 10a. Stete 10b. County | | 10c. City | , Town or Loca | ation | | | | 11 | Od. Inside City Limits |
| notified at rector | Maryland Mont | gomery | B.e | thesd | a | | | | | 1 Yes 2 □ No |
| Directo | 10e. Street and Number | 8002 | | | 10f. Zip Code | | | 10g. Citizen of | What Coun | try? |
| al Di | 7012 Hopewoo | d S+ | | | 208 | 1 7 | | Unit | ed St | tates |
| Funeral | 11. Maritel Stetus | 12. Wes Decedent | | S. 13. W | | lispanic Origin? (an, Mexican, Pue | Specify Yes or N | | ce - Americ | an Indian, |
| by | 1 ☐ Never Merried 2 ☐ Merried 3 ☐ Widowed 4 ☐ Divorced | Armed Forces' 1 Yes 27 If Yes, Give Year or Detes: | | | Yes, specify Cub ☐ Yes 2 ☐ No | | to Hican, etc.) | Specia | ry: With | nite |
| ted | 15. Decedent's | Education | | 16a. Decede | nt's Usuel Occup | pation during most of wo | otina | 16b. Kind of E | Business/Inc | lustry |
| Be Completed | (Specify only highest Elementery/Secondery (0-12) | College (1-4or | 5+) | life. Do | O NOT use retire | d) | nking | | | |
| 00 | 7 | | | Sa | lesman | | | Priv | ate | |
| Be | 17. Father's Neme (First, Middle, La | | | | | | me (First, Middle | , Maiden Sumai | me) | |
| 10 | Menachem Ben | Ellezer | | | | Lea K | atz | | | |
| To Be C | 19a. Informent's Neme/Reletionship Larry Stern/ | p (Type, Print) | | | and the same of the same | and Number or R | | | | |
| į. | | 5011 | | | | ood St. | | | | |
| 1 | 20a. Method of Disposition 1 Suriel 2 □ Cremetion 3 | Removel from State | 20b. PI | lece of Disposi emetery, crema | tion (Name of atory or other pla | ce) | Dete | 20c. Location | - City or To | wn, Stete |
| | 4 ☐ Donetion 5 ☐ Other (Spe | | | lean M | emoria: | 1 | 1/28 | Olney | , MD. | |
| 8 | 21. Signature of Furthral Service Liv | tenbe | 1 | 22. | Name end Addre | ess of Facility | Takoma | Funera | 1 Ho | me. |
| 28 | 1. L. July | of Wour | lot. | _ 2 | 54 Car | | | | | DC 2001 |
| | 23a. Parti. Enter the dispute, or co shock, or heart failure. List or | omplications that cause | d the deeth | | | | | | | Approximate Intervel Between |
| an 💮 | | ., | | | | | | | | Onset end Death |
| al | Immediate Cause (Final disease or condition | Pneı | moni | а | | | | | | B Weeks |
| ner | resulting in deeth) | a | | es e consequ | ence of): | 23113 | | | | |
| lue. | | Chro | nic | Renal | Falur | е | | | 13 | Weeks |
| Examiner | Sequentially list conditions, | 0. | Due to (or | es a consequ | ence of): | | | | | |
| | Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initieted events | C | | | | | | | | |
| edicai | that initiated events resulting in death) Last | | Due to (or | as a conseque | ence of): | | | | | |
| | | d | | | | | | | | |
| Physician/N | | 77 | | | | | | A. In N | 1 | |
| by Physician/M | Part II. Other significant conditions | contributing to death t | out not resu | ilting in the und | derlying cause gir | ven in Pert I. | | | | the cause of death? |
| 표 | Peripheral | Vascular | Dis | ease a | and Gan | grene | 1 | Yas ANO | 3 Prol | bably 4 Unknow |
| d by | | | | | | | 242 Wa | s an autopsy | 24b W | ere autopsy findings |
| Completed | of Foot. | | | | | | | ormed? | av | ailable prior to molation of cause |
| Compl | | | | | | | | | of | death? |
| ပိ | | | | | | | 10 | Yes ZONo | 10 |]Yes 2□ No |
| Be | 25. Wes casa referred to medical axaminer? | Hospitel: | - | | l Ou | hae | eath (Check only | | | |
| | 1 ☐ Yes 🎗 ဩNo | Mnpati | | ER/Outpatient | JU DON | - | Home 5 Res | | | y) |
| D - | 07 Madage of Death | 28a. Dete of Inju | y Year) | 28b. Time of tnjury | 28c. tnju Wo | ryat rk?]Yes 2 □ No | 200. Describe | how injury occu | irred | |
| neral di on: To | 27. Memner of Deeth 1 ☑ Natural 5 ☐ Pending | | | | | 1162 2 140 | 28t Location | (Street and Num | ther or Pure | I Route Number, |
| meral | 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investige 3 ☐ Suicide 6 ☐ Could no | t be | lune Asha | | | | 201. LUCATION | Canal India | Der or riora | i rioute italiioei, |
| meral di on: To | 1 Matural 5 ☐ Pending 2 ☐ Accident investige | t be 28e. Piece of In | jury - At ho c. (Specify | me, tarm, stree | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | | City or To | own, State) | | |
| meral | 1 Matural 5 Pending 2 Accident 3 Suicide 4 Homicide | 28e. Plece of In building, e | tc."(Specify | ") | | - data and alan | | | | nied . |
| meral on: | 1 Matural 2 Accident 3 Suicide 4 Homicide 29e. Certifier (Check only) 27 Medical Ex | 28e. Piece of Inbuilding, e Physician: To the best caminar: On the basis of | of my knov | vledge, death o | occurred at the ti | | e, and due to the | cause(s) and m | | |
| 6 | 1 Matural 2 Accident 3 Suicide 4 Homicide 5 Pending investige 6 Could no determine | 28e. Plece of Inbuilding, e | of my knov | vledge, death o | occurred at the ti | opinion, deeth occ | e, and due to the | cause(s) and m | , and due to | the cause(s) |
| | 1 Matural 2 Accident 3 Suicide 4 Homicide 29e. Certifier (Check only one) 5 Pending investige 6 Could no determine 29e. Certifier (Check only one) | 28e. Piece of Inbuilding, e Physician: To the best caminar: On the basis of | of my knov | vledge, death o | occurred at the ti stigation, in my o | opinion, deeth occ | e, and due to the | e cause(s) and m , date end place 29d. Date sign | , and due to | Day, Year) |
| | 1 Matural 2 Accident 3 Suicide 4 Homicide 29e. Certifier (Check only one) 29b. Signature end title of certifier | 28e. Plece of Inbuilding, e Physician: To the best caminar: On the basis can menner st | of my know of examineti leted. | viedge, death o ion and/or inve | occurred at the tistigation, in my o | opinion, deeth occurse number | e, and due to the urred at the time | cause(s) and m, date end place 29d. Date sign | ed (Month, | Day, Year) |
| meral on: | 1 Matural 2 Accident 3 Suicide 4 Homicide 29e. Certifier (Check only one) 29b. Signature end title of certifier 30. Name and address of person with | t be 28e. Plece of In building, e Physician: To the best caminar: On the basis of and menner s' | of my know of examineti leted. | viedge, death of inventor and/or inventor and/ | occurred at the tistigation, in my o | opinion, deeth occurse number | e, and due to the urred at the time | cause(s) and m, date end place 29d. Date sign | ed (Month, | Day, Year) |
| pletely filled in by the funeral edical Certification: | 1 Matural 2 Accident 3 Suicide 4 Homicide 29e. Certifier (Check only one) 29b. Signature end title of certifier | t be 28e. Plece of In building, e Physician: To the best taminar: On the basis of and menner s' Source of the basis of t | of my know of examineti leted. | wledge, death of ion and/or inve | occurred at the tistigation, in my o | se number | e, and due to the urred at the time | cause(s) and m, date end place 29d. Date sign | ed (Month, | Day, Year) |

STERN, MAX 1.25-00 1245 AM

DHMH 16 Rav 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene \(\) Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Tima of Death 2. Date of Death Month **Physician** JANUARY 28 H. SEWARD MARION 2000 9:30 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore City Good Samaritan Hospital If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 M 2 X F 212-48-6794 52 Yrs. Director Jan. 23, 1948 Baltimore, Md. Usual Residence of Decedent 10a State 10b Count 10c. City, Town or Location 10d, Inside City Limits 1 ¥Yes 2 No Director Baltimore City Md. N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Norma 23a 3213 Southern Avenue 21214 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status "nettural", or Han Pages 1 and 2 should be filed within 72 hours after tent of Health and Mental Hygiene.
rtt: if Itam 27 Ia marked other than "natural", or ites 1 Yes 2 No If Yes, Give Year or Detes: 1 ☐ Never Married 2 X Married 1 Yes 2 No Specify: Specify p White 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Aid

Baltimore City Schools 18. Mother's Name (First, Middle, Maiden Surname)

17. Father's Name (First, Middle, Last)

Andrew Dolinowski Helen Stratamyer

19a. Informant's Neme/Reletionship (Type, Print) Thomas M. Seward (Husband) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3213 Southern Ave. Baltimore, Md. 21214

20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place) St. Stanislaus Cemetery 2/1/00 20c. Location - City or Town, State Baltimore, Maryland

21. Signature of Funeral Service Licensee Milton J Knight Jr

22. Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one clause on each line.

ATHE NO SCIENOTIC COLONARY ACTERY DIRASE

Approximate Interval Between Onset end Deeth

Immediate Cause (Finei disease or condition resulting in death)

STAGE Due to (or es a consequence of)

RENAL DISEASE

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as e consequence of):

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobecco use contribute to the causa of death? 1 Yes 2 No 3 Probably 4 Unknown

DIABETES MELLITUS

SEVERE DIFFUSE DIABETIC NEUROPATHY

24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy nerformed?

SEUERE MAS NUTRIMON 1 Yes 2 No

26. Place of Death (Check only one)

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 Yes 2 No

Hospitel: 1 | Inpatient 2 | ER/Outpatient 3 | DOA

Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

27 Manner of Death 1 Netural 2 Accident 3 ☐ Suicide

4 Homicide

28a. Date of Injury (Month, Day Year) 5 Pending investigation 6 Could not be

28c. Injury at Work? 1 Yes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted.

29b. Signature and title of certifie

29c, License number

29d. Date signed (Month, Day, Year)

D 0035706

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GHANDOUR SATIACITA N HOSPITAL BALTIMONE HD G001

31. Date filed (Month, Day, Year)

32. Registrer's Signature

Registrar

ORIGINAL

Box 68760, P.O. Records. Division of Vital

Baitimore, Maryland 21215-0020

or other 1

Department of Important: If I any Injury or page.

Physician

Examiner

Physician/Medical Examiner

8

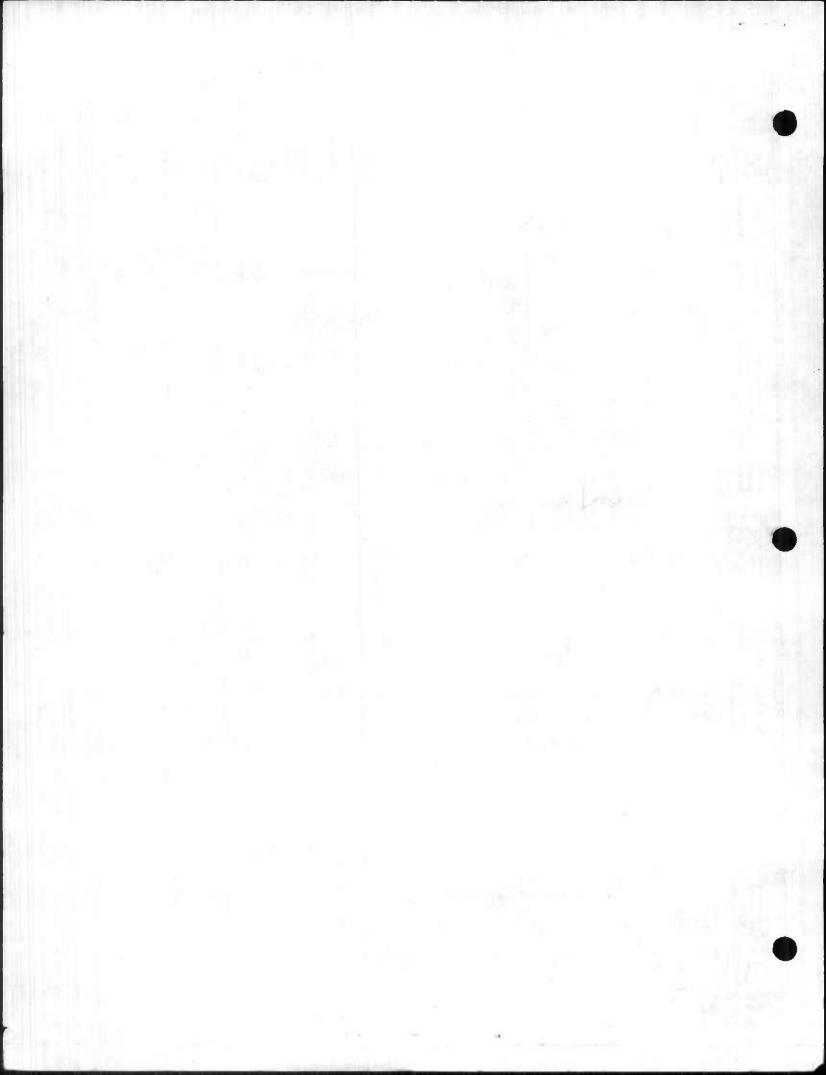
Medical

/Medical

or Attending Physician: After 24 hours after death. filled in by Hospital 9

within 24 hor To the Fune completely fi

DHMH 16 Ray 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Day Yaar 29,2000 2:53 AM Schuman William J4 (0b Januara C. County of Death 4a Facility Nama (II not institution, giva street and number) 4b. City, Town, or Location of Death Baltmore City
If Under 24 Hrs. 8. Data of Birth
(Month, Dey, Year)
10 19 By UI Medical Contact

7. Age (In yrs. last birthday) H-plus UIW If Under 1 Yaar 5. Social Security Number Birthplaca (Stata or Foreign Country) Days 1 M 2□ F Months 212-03-4119 84 10,1915 MARYLAND Usual Rasidence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits N/A BALTIMORE CITY Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 426 GUSRYAN STREET 21224 U.S.A. 12. Was Decedent Evar in U,S.
Armed Forces?

**DOX'as 2 | No
If Yas, Give 1 9 4 5 - 4 6 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian. 11. Marital Status Black, Whita, atc. 1 ☐ Nevar Married 2 ☐ Married 1 Yas 2 No Specify: Specify: 3√ Widowed 4 Divorced WHITE 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Businass/Industry Elementery/Secondary (0-12) College (1-4or 5+) ASSEMBLY LINE GENERAL MOTORS 17. Fathar's Name (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Surnama) WILLIAM JACOB SCHUMAN, SR. JOSEPHINE DILLMAN 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) WILLIAM D. SCHUMAN - SON 1228 GREYSTONE ROAD BEL AIR, MARYLAND 21015 20b. Place of Disposition (Nama of cematery, cremetory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1 Burial 2 Cremation 3 Removal from Stata 4 Donation 5 Other (Specify) OAK LAWN CEMETERY 2/3/00 BALTIMORE, MARYLAND 21. Signature of Funaral Sarvice Licenses 22. Neme and Addrass of Fecility CHARLES S. ZEILER & SON, INC. 23a. Part 1. Entoy the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrast,

Approximate

Approximate Intarval Batween Onset and Death Immediata Causa (Final diseasa or condition rasulting in death) ordice allythmia 5 min Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events rasulting in death) Last Dua to (or as a consequence of): Due to (or as a consequence of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown thilvie renal. 24b. Ware autopsy findinga available prior to completion of causa of death? 24a. Was an autopsy performed? 1 Yes 2 140 1 ☐ Yes 2 ☐ No 25. Was casa rafarred to medical axaminar? 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) 1 Yas 2 No 1 ☑ Appatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 26a. Dete of Injury (Month, Day Year) 28b. Time of 28d. Dascribe how injury occurred 28c. Injury at Work? 1 Netural 5 Pending 1 Yes 2 No invastigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28e. Plece of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Cortifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and dua to the cause(s) end menner es stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and menner stated.

Examine Box 68760. P.O. Division of Vital Records.

Examiner physician and the burial-transit The law requires that the death certificate be executed Physician/Medical USB as þ Completed or Attending Physician: Be 9 this Certification: After within 24 hours after death. To the Funeral Director: Al filled in by

Physician

/Medical

Examiner

MD

Funeral

Director

28a-f show

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flerns 23s

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Hygiene.

Pages 1 and 2 should be to ment of Health and Mental H lant: If them 27 is marked off lary or other traumatic even

Department of important: If any injury or

Physician

/Medical

filed within 72 hours after

Baltimore, Maryland 21215-0020

Director

Funeral

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Completed

Be

completely

DHMH 16 Rev 6/95

Hospital

\$

State Registrar

edicai

29a. Certifier

(Check only one)

29b. Signatura and title of certifier

30. Numer and addrass of person who comple

31. Data filed (Month, Day, Year)

Chian

Johns H-pkiL 32. Registrar's Signatura

MO

Meen

fed cause of death (Item 23a) (Type, Print) Medical

29c. License number

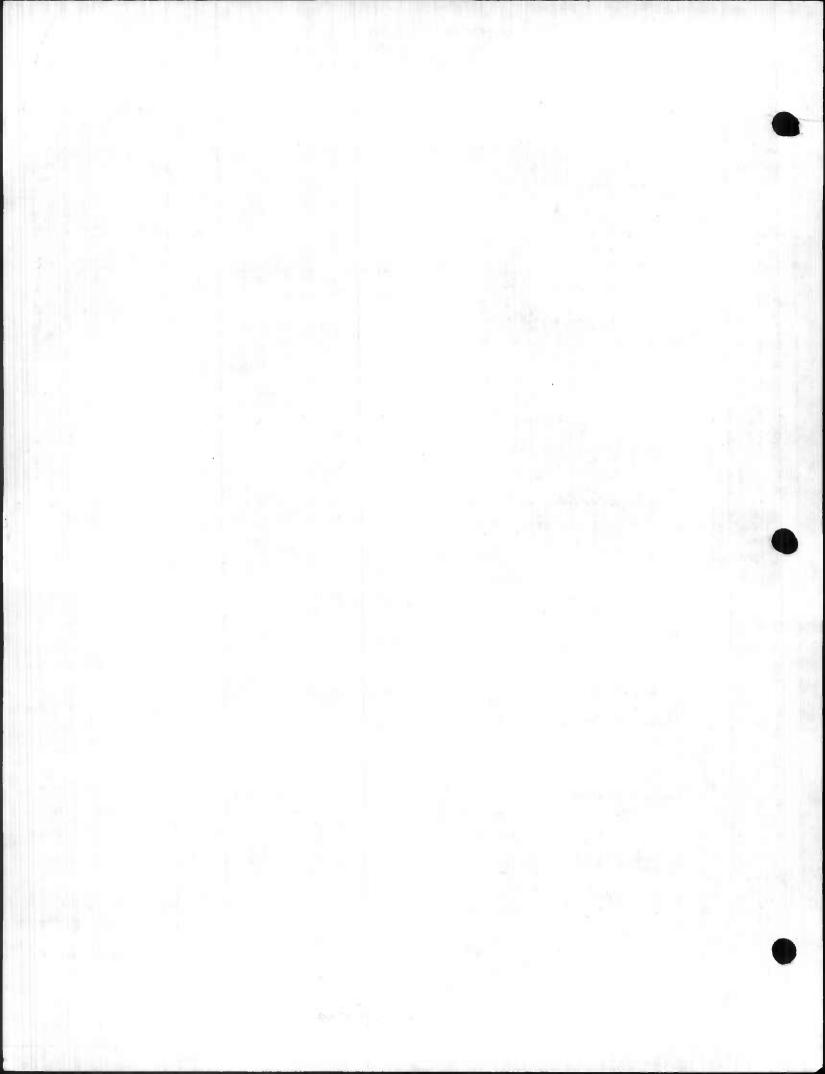
KAUGIN 29

29d. Date signed (Month, Day, Year)

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Conte

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month Day MARY SUMMERVILLE JANUARY 2.14 au 26 2000 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death HOSPITAL CENTER BALTIMORE HARBOR If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) 10 M 20 F Hours Months Days Yrs. 87 31912 MARYLAND 218-18-2986 Usual Residence of Deceden 10e Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Nas 2 No Md. N/A BALTIMORE 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 2804 N. DENHAM CIRCLE 21225 U.S.A 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forcas? 1 Yas 2 No If Yas, Giva 14. Race - American Indian, Black, White, etc. 1 Nevar Married 2 Married AFRO-AMERICAN 1 Yas 2√2 No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) 6ТН LABORER (CANNER) FACTORY 17. Father's Nema (First, Middla, Last) 18. Mother's Neme (First, Middle, Maiden Surnama) SARAH BREWSTER JOHN SUMMERVILLE 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19e. Informent's Name/Ralationship (Type, Print) ANNETTE MANIGO-MASSEY /grandchild/3109 Kentucky Ave. BALTO, MD. 21213 20b. Place of Disposition (Nama of cematary, cremetory or othar place) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from State 4 ☐ Ponation 5 ☐ Other (Specify) FEB. 2, 2000 BALTO, MD. MT.ZION CEM. atura of Funaral Sarvica Licensae 22. Nama and Address of Facility CALVIN B. SCRUGGS FUNERAL HOME maais 1412 E. PRESTON STREET BALTO, MD. 21213 Part1. Entar tha disaasa, or complications thet caused tha deat shock, or haert feilure. List only ona causa on each lina. Do not entar the mode of dying, such es cardiac or raspiretory errest, Approximete fnterval Between Onset and Death Immediata Causa (Final LUNG CANCER year diseasa or condition resulting in daath) Due to (or as a consequence of): Sequentially fist conditions, if any, laading to immadiata cause. Enter Undarlying Cause (Disease or injury that initiated avents rasulting in death) Last Dua to (or as a consequence of): Dua to (or as a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert f. 23b. Did tobacco use contribute to the cause of death? NO Yes 2 No 3 Probably 4 Unknown OBSTRUCTIVE PULMONARY 24b. Ware sutopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? CONGESTIVE HEART FAILURE 1 ☐ Yes 2 ☐ No 1 Yes 2 0 No 25. Was casa refarred to medical axaminar? 26. Placa of Death (Check only one) Hospital: 1 Yas 2 No Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) Inpatiant 2 ER/Outpatient 3 DOA 27. Manger of Death 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Netural 5 Panding invastigation 1 ☐ Yas 2 ☐ No 2 Accidant

The law requires that the death certificate be executed pue P.O. Box 68760, attending physician for use as the buria 2 Records, certificate Division of Vital To the Hospital or Attending Physician; within 24 hours after death.

To the Funeral Director; After this certifica completely filled in by the Iuneral director; p

Physician /Medical

Examiner

Examiner Physician/Medical Be Completed Medical Certification: To

Physician

/Medical

Examiner

Funeral

Director

show

289-1

must be

"natural", or hams 23a or

Hygiens.

filed within 72 hours after

Pages 1 and 2 should be Department of Health and Mental Important: If Nem 27 is merked of any Injury or other traumatic eve

Baltimore, Maryland 21215-0020

Director

Funeral

à

Completed

Be

State Registrar

(Check only one) 29b. Signeture end title of certifier Abhay

29a. Certifiar

3 Suicida

4 Homicide

Maghekas

6 Could not be datarmined

Resident Myselan 30. Nama and address of person who complated cause of deeth (Item 23a) (Type, Print)

28e. Pleca of Injury - At homa, farm, street, factory, office building, etc. (Specify)

29c. License number 111949

Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.

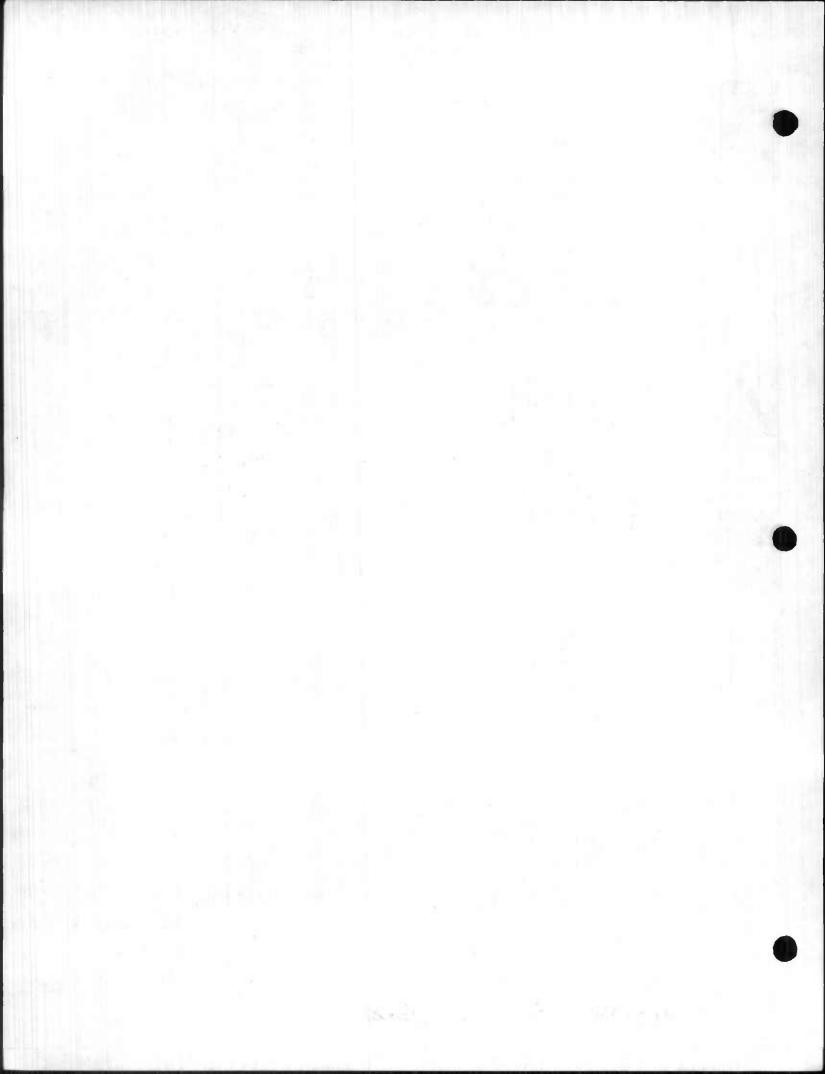
29d. Data signed (Month, Day, Year) JANUARY 26 2000

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

Harbot Kospital Center 300 (S. Kanouer St. Baltimore Mp 21225

31. Data filed (Month, Day, Year) 32. Registrar's Signe 2000 JAN31 Docksk

DHMH 16 Rev 6/95



Physic /Medi Exami

Funeral Director

permit. Pages 1 and 2 should be filled within 72 hours after death with the Marylan Department of Health and Mantai Hygiens. Important: If Item 27 is marked other than "natural", or harns 23a or 28a-f show any highey or other traumatic event, the Medical Examiner must be notified at 2006.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

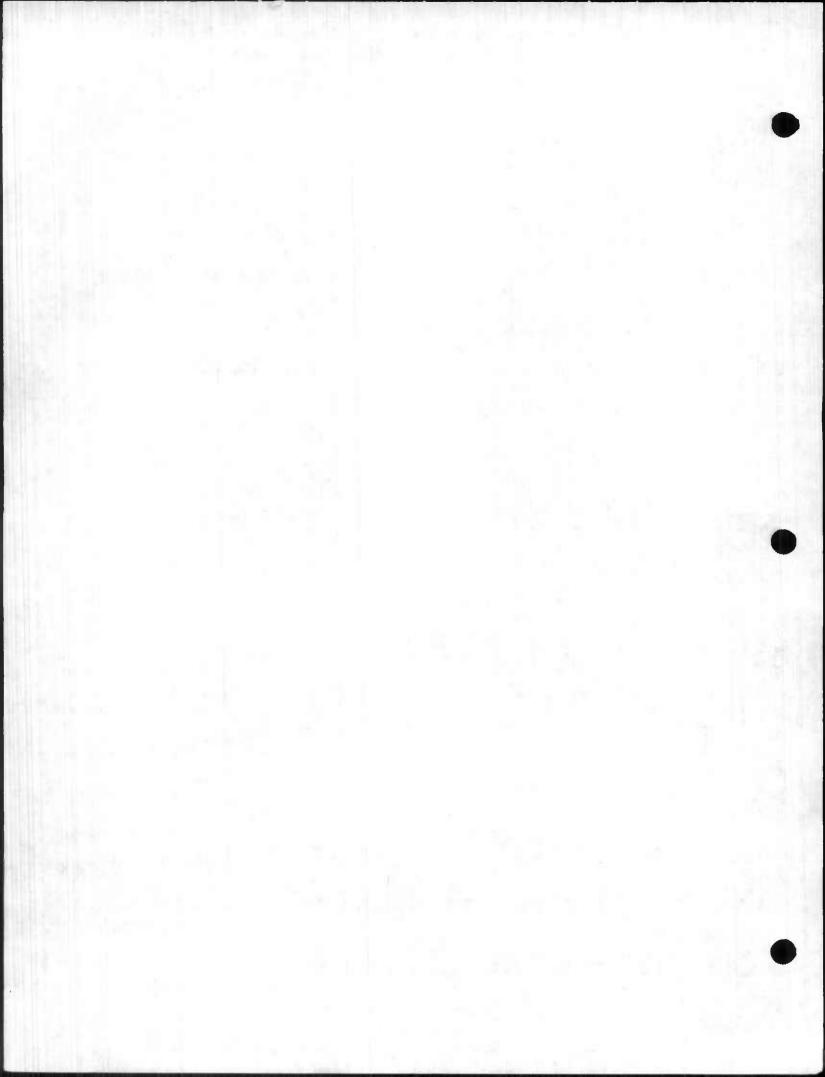
Baltimore, Maryland 21215-0020

| | | | | | Cer | tificat | e of | Death | | | Reg. | No. | U | UZ | 103 |
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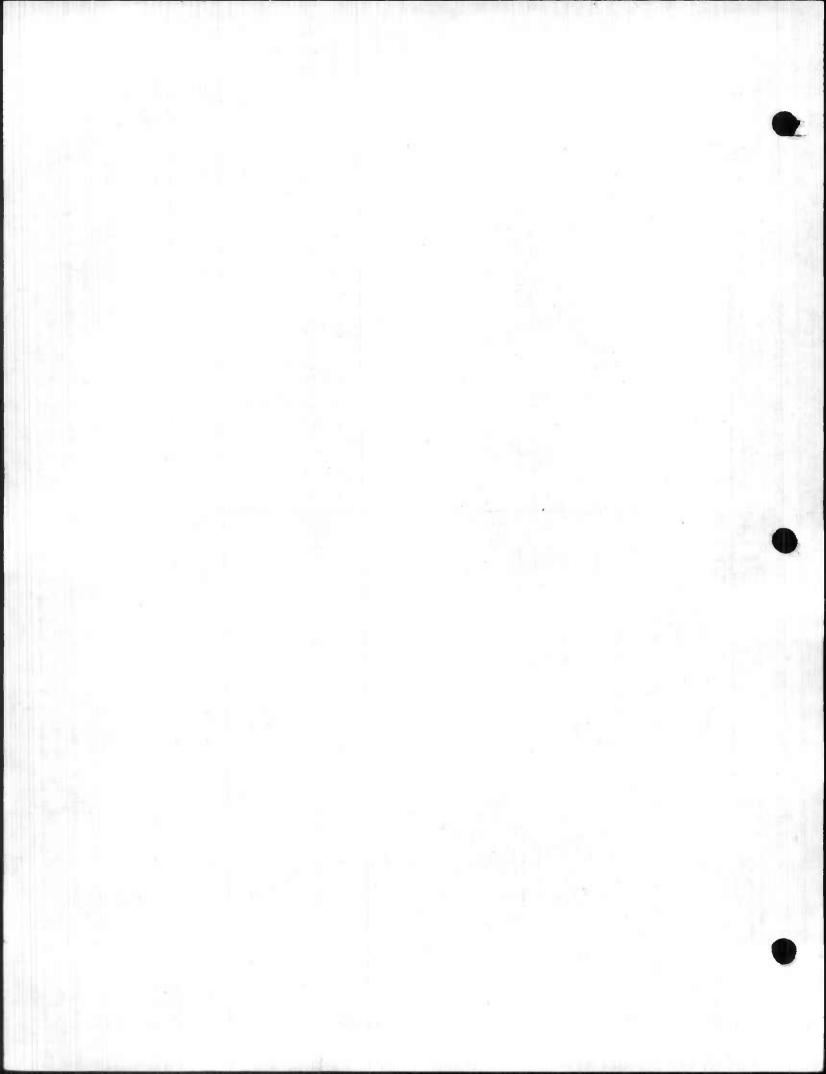
State Registrar

31. Data filed (Month, Day, Year) JAN 3 1 2000 32. Registrar's Signatura

Sparks



amend item 11 per fh G782 4/6/00 Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 10:30pm Jan. **Physician** 199y, 2000 Andrew Thomas /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Gilchrist Nursing Home If Under 24 Hrs. If Under 1 Year 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2□ F Days Months Hours 217-22-0978 74 SC Director 03-03-25 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits r 28a-f show MD NA Baltimore XXYes 2 No Director 30 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21201 102 W. North Avenue USA Funeral 0 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 X Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: 21215-0020 by 3 ☐ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ANDREW Elementary/Secondary (0-12) College (1-4or 5+) NA Hygiene. various trades High Sch. Grad Laborer Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be finent of Health and Mental I ant: If Item 27 is marked of Little John Thomas Mattie Robert 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21201 19a. Intormant's Neme/Relationship (Type, Print) 102 W. North Avenue Baltimore, Maryland HOMAS, Reginald Thomas Baitimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State MD. 1 Burial 2 Cremation 3 Removal from \$ 눌청 permit. Page Department Important: If any Injury or Garrison Forest VA Cem. 01+31-2000 Owings Mills 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Baltimore, Maryland 21202 Funeral Service Liceris WM.C.March FH 1101 E. North Avenue at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, so on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final months disease or condition resulting in death) Examiner and Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) 68760, Physician/Medical Due to (or es a consequence of) Box 980 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 0 1 Yes 2 No 3 Probably 4 Unknown ۵. Records, by 8.8 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 Yes 1 ☐ Yes 2 ☐ No of Vital Physician: Be 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? Division After Attending 1 Netural 5 Pending 1 Yes 2 No 24 hours after death. 2 Accident investigation 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of tnjury - At home, farm, street, tactory, office building, etc. (Specify) filled in by 4 ☐ Homicide 8 Hospital 18 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner es stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner stated. 29a. Certifier (Check only one) within 2 2 29b. Signatura Intle of certifier 29c. License number 29d. Date signed (Month, Day, Year) uno 20, 2000 30. Name and address of person w and cause of death (Item 23a) (Type, Print) 6-bmc 670 1 N. Charles St. Bolto. Md 2,208 31. Date tiled (Month, Day, Your) 32, Flagistrar's Signeture State JAN 3 1 2000 Registrar DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

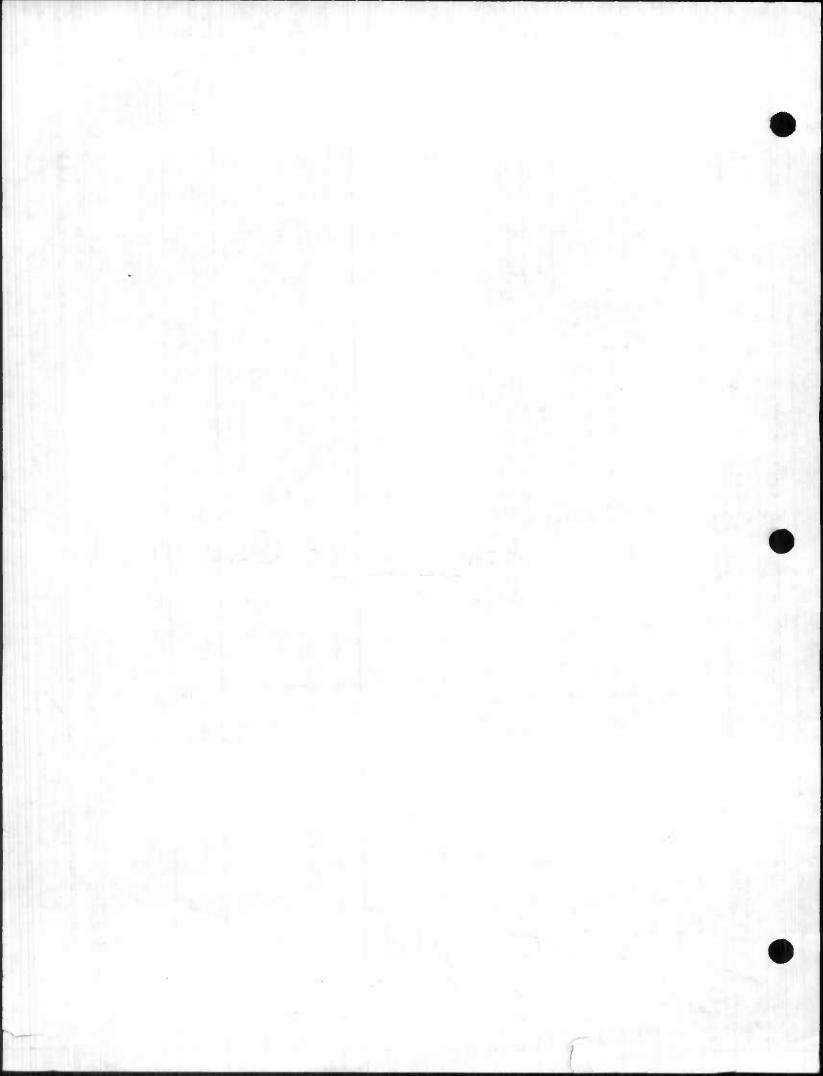
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3 Time of Death Month **Physician** Thomas Tillett, JANAURY 24, Sr. 2000 1820 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner GOOD SAMARITAN HOSPITAL BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1☑M 2□F 73 Yrs. 214-22-6767 Director October 23,1926 Maryland Usual Residenca of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Baltimore Parkville 1 ☐ Yes 2 ☑ No r 28a-f a Directo 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be n 7907 Elmhurst Avenue 21234 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Reca - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 XYes 2 No If Yes, Give 1 Never Merried 2 Married 8 Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No rr Yes, Give Yeer or Dates: WWII à Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Cotlege (1-4or 5+) Elementery/Secondery (0-12) Hygiane Accountant U.S. Government 18. Mother's Neme (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental Rose-Marie Frick James Tillett 7 is merke traumatic 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) Winifred (Freeland) Tillett/Wife 7907 Elmhurst Avenue Parkville, MD nt of Health t: If Nem 27 i 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 8 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Stete Chesapeake Crematory, Inc. 1/27/2000 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Stephen D. Lohrmann P.A. Green Pastures Drive Baltimore, MD 21286 Lama Hardesly 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate tnterval Between Onset and Death **Physician** /Medical Immediate Cause (Final diseese or condition resulting in death) Examiner Physician/Medical Examiner The law requires that the death certificate be axecuted Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or es a consequence of) use as the Box P.0. 23b. Did tobacco use contribute to the cause of pleath? detached Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown signed by of Vital Records, by ed bluods 24b. Were autopsy findings Completed 24a. Wes an autopsy available prior to completion of cause of death? page 2 certificate has 1 Ves 2 □ No 1 No 2 No To the Hospital or Atlanding Physician: I within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 8 25. Was case referred to medicat examiner? 26. Piace of Death (Check only one) Hospital: 1 Inpatient **ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1XX es 2 No 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division Injury 1 Netural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner as stated.

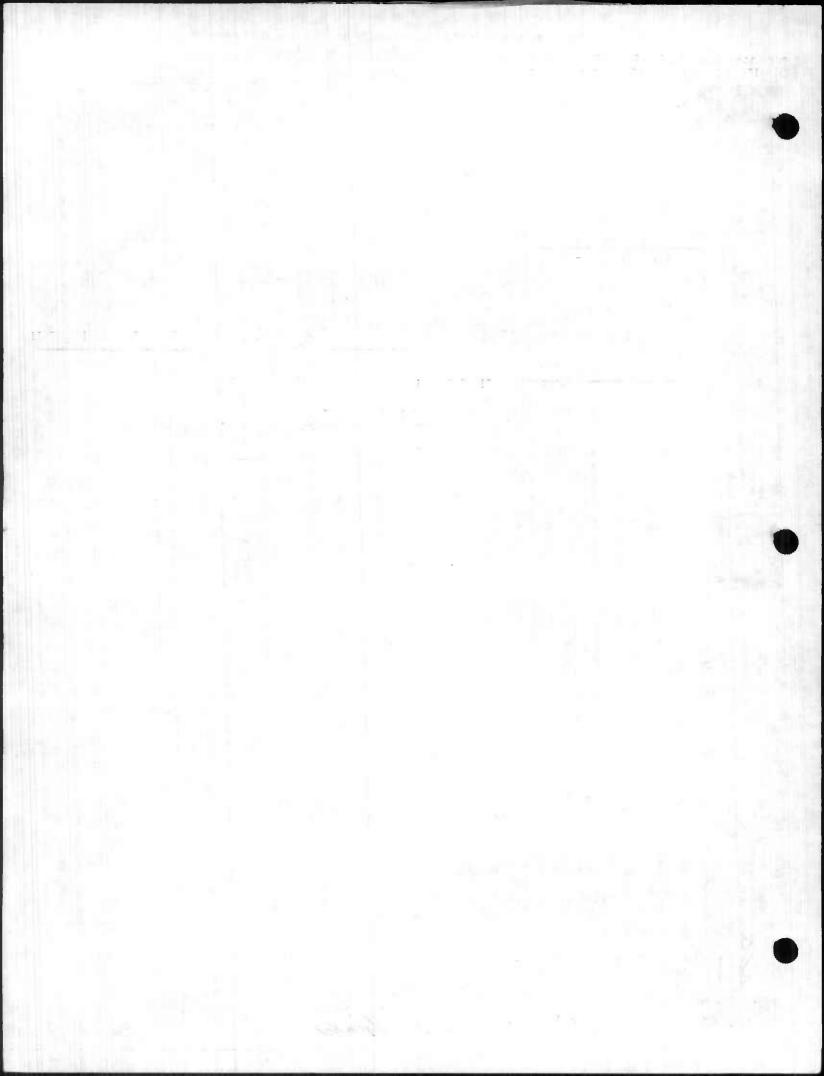
**Continuing Physician: To the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end manner steled. edicai 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of cartifier JANAURY 25, 2000 O.C.M.E. 30. Name an who completed cause of death (Item 23a) (Type, Print) Tames 111 Penn Street, Baltimore, Maryland 21201 31. Date fil Duy, Year, 32. Registrar's Signeture State JAN 3

Registrar **DHMH 16 Rev 6/95**



| 1. | | ne (First, Middle, La | . 2/7/2000 A | 170 | Certificate of | Dealli | 2. Dete of D | | 3. Time of Death | |
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| r ^{4e} | | | ve street end numbe | | | 4b. City, Town, o | r Location of Dee | | of Deeth | |
| | | tospital | | 1timo | | Baltin | | Ireth Iv | Piethologo (State or Familia | _ |
| | Social Security N 27 – 32 – | | Sex 1 □ M 2 1 F 7. A | Age (In yrs. fe 89 | Yrs. Months De | eys Hours Mi | 8. Date of B (Month, D | 22,1910 | Birthplece (State or Foreign Country) VIRGINIA | |
| | sual Residence o | f Decedent 10b. County | | 100 City | Town or Location | | | | 10d. Inside City Limits | |
| 10 | M.D. | Too. County | | | FIMORE | | | | 1 A Yes 2 No | |
| 6 | | ER COUR | | | 10f. Zip Coc 212 | ^{de} 207 | | 10g. Citizen of V U • S • | | |
| | , Marital Stetus | | 12. Was Deceder Armed Forces | \$? | 13. Was Decedent If Yes, specify (| of Hispenic Origin? Cuben, Mexican, Pu | (Specify Yes or Norto Rican, etc.) | | ce - American Indien, ck, White, etc. | |
| | 3 Widowed | ried 2 Married 4 Divorced | 1 ☐ Yes 2 ☑ If Yes, Give Year or Detes | | 1 □ Yes 2 🔀 | No Specify: | | Specify | BLACK | |
| _ | (Sne | 15. Decedent's E | ducation | | 16a. Decedent's Usuel Oc (Give kind of work do | ccupation | rorkina | | usiness/industry | |
| | Elementery/Second 9TH GR | | College (1-40 | or 5+) | life. DO NOT use re | tired) CMALL DI | | TIMOTH | NT & SERVICE STATION | 01 |
| 17 | | (First, Middle, Last Y ROBE | RSON T | IMOTHY F | ROBINSON | 18. Mother's N LULA | | le, Meiden Sumen | ne) | |
| | 9a. Informent's N MMA ST. | ame/Relationship | (Type, Print) : DAUGHT | ГER | 196 CANISMER SS CO | reet and Number or CRT RUAD COURT B | Rural Route Num | nber, City or Town, | Stete, Zip Code) 21207 | |
| 20 | le. Method of Dis | | Removal from Stat | 20b. Ple | ce of Disposition (Neme of metery, cremetory or other CIOCH CEME) | plece) | 2/3/00 |) | City or Town, State | |
| - | 4 Donation | 5 Other (Special | (y) | ANT | 22. Name and Ac | deepe of Espility | 1-00, | | A, VIRGINIA | |
| 2 | 1. Signature of Pt | Unierei Service Lice | E. Mis | tton | | | | | FUNERAL HOM | F |
| 2 | 3e. Part1. Enter t | the disease, or con | nplications that caus | sed the deeth. | 2501 GV | VINNSPAL | LS PKW | Y BALTO | ., M. D. 21216 | - |
| | | , | One ceuse on each | ine. | Do not enter the mode of | dying, such as card | ec or respiretory | arrest, | Intervel Between | |
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ORIGINAL



Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year 164 **Physician** ANNIE WYNN
4a Facility Name (If not institution, give street and number) IAN 20 00 /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE 5. Social Security Number HOALTH CARE If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral 1 M 2 F Days Months Hours 212-36-7182 Yrs. 0 Director AN Usual Residence of Decedent 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location 28a-f show 1 Yes 2 No Directo WING TIMORE 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ò J. S. A. 14. Race - American Indian, Items 23a 21117 Funeral EIA 11. Marital Status Was Decedent Ever in U,S. Armed Forces?

1 Yes 2 No H Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: "natural", or Black by 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry I Hygiene. Elemantary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled wir Department of Health and Mertal Hygieru Important: if ham 27 is marked other tha any Injury or other traumatic avant, ma.) DDGs. omestic bth NA DWG 17. Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Sumame) Be tie WIGGINS a UNKNOWN 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) KITTERSIEA MOZBUND - MOZSON WASON Quings Mills 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 29/2000 JATIONA TAR 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Funeral Home West, INC. march 4300 Wabash Aue md 21215 1 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shows, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical MA Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated evants resulting in death) Last Dua to (or as a consequence of) RADY CARDIA Box 68760 Physician/Medical Due to (or as a consequenca of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Whknown 1 Yes 2 No þ 24b. Ware autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 2 1 No 2□ No 1 Yes 1 Yas NAME COVOR 25. Was case raferred to medical examiner? 88 26. Place of Death (Check only ona) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) Certification: To 1 npatient 2 ER/Outpatient 3 DOA 27. Manne of Deeth 28a. Data of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be datamined 3 Suicide 28e. Place of Injury - At homa, farm, street, factory, offica building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) after 4 Homicide To the Hospital within 24 hours a Forthe Funeral C Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 13592 2000 30. Name and addrass of person who completed caysa of death (ftam 23a) (Type, Print) ALEXANDER JOHNSON JAN 3 1 2000 32. Registrar's Signatura State Registrar

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month 655 PM Zink Veto I. 00 01 27 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Balthore, MO Johns Honking Bayview Melical Center Baltimore If Under 1 Year | If Under 24 Hrs. | Birthplace (State or Foreign Country) 5. Sociel Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Dete of Birth (Month, Day, Year) Hours Months Deys 180 M 2□ F 73 220-14-1217 9-5-1926 Maryland Usuel Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d Inside City Limits MD Baltimore 1 ☐ Yes 2 N No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7136 Gough Street 21224 USA 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Race - American Indian, Black, White, etc. 1 Never Married 2 Merried 1 Yes 2 No Specify: White Specify: 3 Widowed 4 □ Divorced Year or Dates: 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementery/Secondery (0-12) 1 2 t h College (1-4or 5+) Hamburger's Clothing Salesman 17. Father's Neme (First, Middle, Last) 18 Mother's Neme (First Middle Maiden Sumame) John Zink Elizabeth Zajaunkankaus 19e. Informent's Neme/Reletionship (Type, Print) Son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Stephen Zink 5042 Springhouse Circle, White Marsh, MD. 21237 20b. Ptece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 1/31/2000 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cemetery 21. Signeture of Funerel Service Licensee 22. Neme and Address of Fecility Joseph N. Zannino Jr. Funeral Home 263 S. Conkling Street, Baltimore, Maryland 21224 annews 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only use cause on each line. Approximate Intervat Between Onset end Death Immediete Cause (Final Respiratory Arrest 3 Months disease or condition resulting in deeth) Due to (or es e consequence of): Metastatic Lung Cauler Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or es a consequence of) Due to (or es a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy tindings evailable prior to completion of cause of death? 24e. Wes an autopsy 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case reterred to medical 26. Place of Deeth (Check only one) Hospitei: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Dete of Injury (Month, Day Year) 27. Menger of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 1 Meturel 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide

Examiner physician and the burial-transit that the death certificate be executed P.O. Box 68760 Physician/Medical been signed by the s should be detached Records. þ or Attending Physician: The law requires Completed Division of Vital 8 edical Certification: To this After death. To the Hospital or Attendition within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

Physician

/Medical

Examiner

Funeral

Director

must be notified at

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permit. Papes 1 and 2 should be filled we Department of Health and Merital Hygien important: if flem 27 is merited other tha any Injury or other traumatic event, IDE, 2006.

Physician /Medical

Examiner

Baltimore, Maryland 21215-0020

Director

Funeral

by

Completed

Be

the Maryland

State

Registrar

29b. Signeture end title of certifier

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, end due to the ceuse(s) and menner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the ceuse(s) end menner steted. 29d. Dete signed (Month, Day, Year)

OLNEY, MO

RES- 0001

1/27/00

30. Neme and address of parson who completed cause of death (Item 23a) (Type, Print)

Mathew J. Olnes, MD

John Hopkin Bayview Medical center Baltimore MD

31. Date filed (Month, Day, Year)

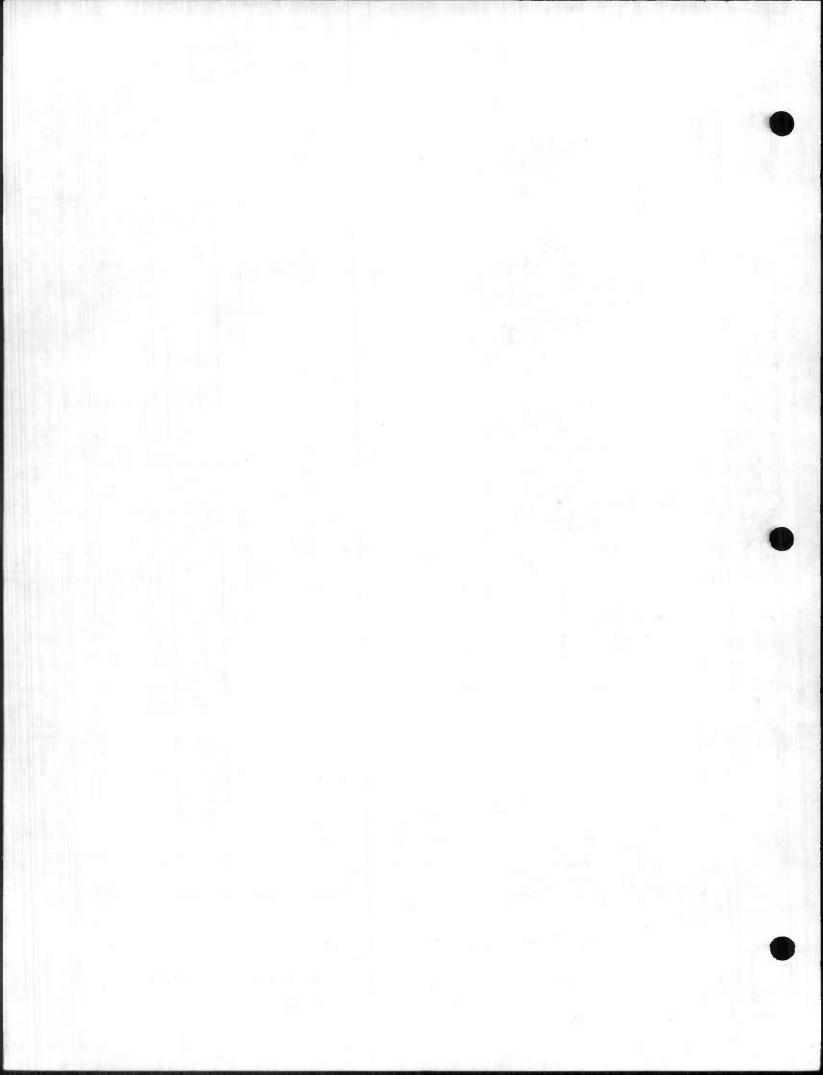
100 ---

29e. Certifier (Check only one)

> 32. Registrer's Signeture 2000 ▶ JAN 3

bonks

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth **Physician** Month EILEEN S. ATKINSON JAN.8, 2000 6:25 PM /Medical 4e. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** NATIONAL LUTHERAN HOME ROCKVILLE MONTGOMERY If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Dey, Year) 7. Age (In yrs. lest birthday) Birthpieca (State or Foreign Country) **Funeral** Deys 1 M XXX 91 219-36-8393 Yrs. Director MAR. 17, 1908 NEW YORK Usual Residence of Decedent with the Maryland 10a Steta 10b. County 10c. City, Town or Location 10d. Inaide City Limits 28a-f show traumatic event, the Medical Examiner must be notified at MONTGOMERY MD. ROCKVILLE Yes 2 No Director 10e. Streat end Number 10f. Zip Code 10g. Citizen of Whet Country? ö 9701- VEIRS DR. 20850 USA items 23a Funeral 12. Wes Decedant Ever In U,S. Armed Forces? 1 ☐ Yas 2 ☒ No If Yes, Give Yaer or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Ricen, atc.) 14. Race - American Indian, Bleck, Whita, etc. permit. Pages 1 and 2 should be filed within 72 hours effer c Department of Health and Mentel hygiene. Important: If Item 27 is marked other than "natural", or iten any Injury or other traumatic event, the Medical Exercises 1 ☐ Never Merried 2 ☐ Married 21215-0020 1 Yes 2 No Specify: Specify: WHITE þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done duning most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grede completed) Elamentary/Secondary (0-12) College (1-4or 5+) 12 SCHOOL TEACHER ELEMANTARY Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumame) Be FREDERICK SMYTHE BEATRICE HEYES 2 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Addresa (Street end Number or Rural Route Number, City or Town, State, Zip Code) REV.DR. REICHARD-EXECUTOR 9701- VEIRS DR., ROCKVILLE, MD. 20850 20e. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other p 20c. Location - City or Town, Stete 1 ☐ Buriel 2 X Cremetion 3 ☐ Removel from State METROPOLITAN CREMATORY-1/10 ALEXANDRIA, VA. 4 ☐ Donetion 5 ☐ Othar (Specify) 21. Signatura of Sunerel Sovice Licensee 22. Name end Address of Fecility HYSONG CO., INC. t et caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory WASH., DC Approximete Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) Examiner Examiner The law requires that the death certificete be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Leat Due to (or es e consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cease given in Pert I. 23b. Did tobacco use contributs to the cause of death? 3 Probably 4 Unknown 1 Yss 2 No by 24b. Wera autopsy findinga avellable prior to Be Completed 24e. Was en autopsy performed? completion of cause of death? certificate has by director, page 2 st 1 ☐ Yea 2 ☐ No or Attending Physician: 25. Wes cese referred to medical exeminer? 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 0 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA s after death.

N Director: After this ad in by the funeral d After this 27. Menner of Deeth Certification: 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred 5 Pending investigation 1 Netural 1 Yes 2 No 2 Accident 8 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours af To the Funeral Di completely filled is Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicat Examiner: On the basis of examination and/or invastigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Dete signed (Month, Dev. Year) 30. Name and eddress of person who completed ceuse of daeth (Item 23a) (Type, Print) KARESH- 9701- VEIRS DR., ROCKVILLE, MD. DR. CHARLES W. 31. Dete filed (Month, Dey, Year) 32. Registrar's Signature State JAN 1 4 2000 Registrar

DHMH 16 Ray 6/95

JAN 1 2000 January January

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

| 1. Decedent's Nama (First, Mid | idle, Last) | | | | | 2. Data of Dea | Reg. No. | | 3. Time of Death |
|--|---|------------------------|------------------------|------------------------------------|--|--|--------------------|------------------------------------|---|
| an Merle P. | Arrington | | | | | Month Januar | y 4, 20 | Year 00 | 4:45 p.m. |
| 4a Facility Name (If not institut | | | | | 4b. City, Town, or | Location of Death | 4c. County | | 4145 Ptime |
| 3149 Queens C | hapel Road | #103 | | | Mount Ra | ainier | Princ | e Geor | ge's |
| 5. Social Security Number 577–12–6593 | 6. Sex 1 □ M 2 □ F | Aga (In yrs. 93 | | If Under 1 Year Months Days | If Under 24 Hrs Hours Min | | , Year) , 1906 | 9. Birthplac Country) Virgin | a (Stete or Foreign |
| Usual Residence of Decedent 10a. State 10b. Cour | nty | 10c. Cit | y, Town or Local | tion | | | | 10d. | Inside City Limits |
| | ce George's | | nt Raini | | | | | | 1∏ Yas 2□No |
| Maryland Prin | ce deorge s | Hou | ne Kaliii | 10f. Zip Code | | | 10g. Citizen of W | Vhat Country | ? |
| 3149 Queens Cl | napel Road | | | 20712 | | | U.S.A. | | |
| 11. Marital Status 1 Never Married 2 M 3 M Widowed 4 Divorce | 12. Was Decer Armed For 1 Yes Give | ces? 2 ⊠ No | HY | s Decedent of I es, specify Cub | lispanic Origin? (an, Mexican, Pue Specify: | Specify Yas or No- rto Rican, etc.) | | e - American k, White, etc. | |
| | ent's Education hest grada complated) College (1- | 4or 5+) | (Give kin life, DO | NOT use retire | during most of wo | orking | 16b. Kind of Bu | | |
| 17. Fathar's Name (First, Midd | le (est) | | Bookke | eper | 18 Mother's Ne | me (First, Middle, | | | al Bank |
| (Unavailable) | | | | | Lillian | | | -/ | |
| (Unavailable) 19a. Informant's Name/Relation | | | 19b. Mailing | Address /Stree | | Bural Route Number | r. City or Town | Stete, Zio Co | ode) |
| Paul P. Manus | | on | | | | Salisbur | | | |
| 20a. Method of Disposition | , | 20h F | Place of Dispositi | ion (Neme of | | Date | 20c. Location - | | |
| 1 🖾 Burlal 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other | | 1816 | dar Hill | 7. | | 01/07/00 | Suitlan | d. Mar | vland |
| 21. Signature of Funeral Servi | | CE | | | | 1 | | u, nar | y Land |
| 23a. Part1. Enter the disease, | nee Yas | eh | 47 | 39 Balt | imore Av | Home, P.A | attsvil | | 20781 |
| shock, or heart failure. Li Immediate Cause (Final disease or condition resulting in death) | | rioscle | erotic C | | scular D | isease | | O | tervel Between nset and Death |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | б. | Due to (d | or as a conseque | nce of): | | | 76 | | |
| u | C | Dua to (d | or as a conseque | nce of): | | | | | |
| 2 | 0. | | | | | | | İ | |
| Part II. Other significant cond | itions contributing to dea | ath but not res | ulting in the unde | erlying cause gi | iven in Part I. | | Yes 2K No | | ne cause of death? bly 4 Unknown |
| | | | 14.6 | | | 24a. Was perfo | an autopsy med? | avails | autopsy findings able prior to eletion of cause ath? |
| 5 | | | | | | 10 | ras 2∭ No | 1 D Y | res 2□ No |
| 25. Was case referred to med | cal | | | | 26. Place of D | eath (Check only o | ne) | | |
| axaminer? 1 ☐ Yas 2 ☒ No | Hospitel: 1 🗆 Ir | patient 2 | ER/Outpatient | 3□ DOA O | her: 4 Nursing | Home 5 N Resid | dence 6 Oth | er (Specity) | |
| 27. Manner of Death 1 🖾 Netural 5 🗆 Pen 2 🖸 Accident inva | stigation | Injury n, Dey Year) | 28b. Time of Injury | 28c. Inju Wo M 1 | iry at ork?] Yes 2 ☐ No | 28d. Describe | now injury occur | red | |
| | buildin | g, etc. (Specil | | | | City or To | | | |
| 29e, Certifier 1 Certifier (Check only one) | ying Physician: To the ba at Examiner: On the ba and mann | sis of examine | | | | curred at the time, | date end placa, | and dua to th | ne cause(s) |
| 29b. Signature and title of cert | fier | 2 , | | 29c. Licen | se number | | 29d. Date signe | d (Month, Da | y, Year) |
| Kun | can | WI | ew) | D018 | 352 | | January | 5, 20 | 00 |
| 30 Name and address of sore | on who completed sever | of death /lto- | n 23a) /Tuna De | int) | | | | | |
| 30. Name and address of pers Paul A. DeVor | | | | | Hyattsvil | lle, MD 2 | 0781-14 | 35 | |

DHMH 16 Rev 6/95

ORIGINAL

Same To the Market State of the
Please Type or Print in Black Indelible Ink. Assure Ali Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 02107

| | 1. Decedent's | Name (First, Middle, L. | ast) | | | | Death | 2. Date of De | Reg. No. | 3. T | ime of Death |
|--|--|--|--|--|--|--|---|--------------------------------------|--|--|--|
| sician | 100000000000000000000000000000000000000 | A MAY ALL | | | | | | Month | Day | Year | |
| edical iminer | 4a Facility Ne | me (If not institution, gi | ive street and number, |) | | | 4b. City, Town, or | | 03 20 4c. County | | 3:14AM |
| mme | CROFTO | ON CONVAL | ESCENT R | EHAB | BILITAT | TON | CROFTON | | ANNE | ARUNDE | EL |
| ral | 5. Social Secu | urity Number 6. | Sex 7. A | | tast birthday) | If Under 1 Year Months Days | If Under 24 Hrs | 8. Dete of Birt | th | | State or Foreign |
| tor | | 8 7911 | 1□ M 2□XF | 94 | Vee | | | MAY 1 | | MARYLA | |
| Director | 10a. State | 10b. County | | 10c. Ci | ty, Town or Loca | ation | | | | 10d. Ins | side City Limits |
| tor | MARYL | AND ANNE | ARUNDEL | AN | NAPOLI | S | | | | 10 | Yes 2 No |
| Directo | 10e. Street an | d Number | | | | 10f. Zip Code | | | 10g. Citizen of | What Country? | |
| | | TUDO COU | _ | | | 21401 | | | | STATES | |
| by Funeral | | Married 2 Married wed 4 Divorced | 12. Wes Decedent Armed Forces 1 Yes 27 If Yes, Give Year or Dates: | ? No | | as Decedent of Yes, specify Cut | Hispanic Origin? (Span, Mexican, Puer Specify: | Specify Yes or No to Rican, etc.) | | ce - American Indick, White, etc. | ian, |
| Completed | | 15. Decedent's E (Specify only highest gr | | | (Give ki | nt's Usuel Occu | during most of wo | rking | 16b. Kind of B | Susiness/Industry | |
| dH | | /Secondary (0-12) | College (1-4or | 5+) | | NOT use retire | 9d) | | HOME | | |
| | | ame (First, Middle, Las | () | | HOMEMA | KEK | 18. Mother's Ner | me (First, Middle, | | ne) | |
| o Be | HENRY | PADDY | | | | | MAMMIE | SMITH | | | |
| - | Land I Washington | nt's Name/Relationship | | | 1000000 | - The state of the | t and Number or Ri | | | |) |
| | MILDR | ED SHERBERT | C (DAUGHTER | | | TUDO CO | URT ANNA | POLIS, M | D. 21401 | 1 | |
| | 20a. Method o | of Disposition | Removel from State | | Place of Disposit cemetery, crema | tory or other pla | | Date | | - City or Town, St | |
| | 4 □ Dona | tion 5 Other (Speci | ify) | LA | KEMONT | | | 1-4-00 | DAVIDS | SONVILLE | ,MD. |
| | 1 /h | M Funeral Sterrick Life | | | 29 | | GE MONS ISLA | AND ROAD | EDGEWAT | FUNERAL : TER,MD.2 | |
| | 23a. Part1. E shock, o | nter the disease, or con r heart failure. List only | mplications that cause y one cause on each l | d the deat line. | th. Do not enter | the mode of dy | ing, such es cardie | c or respiretory a | rrest, | Interv | oximete val Between t and Death |
| | Immediate Ca disease or co resulting in de | ndition | cor | 100 | trace | hoa | + | 1 1 | | | |
| | resoning in oc | saur) | | 1/ | | / 000 | Y / | alun | | 150 | Lays |
| 100 | resulting in the | samj | | 1/ | or as a conseque | ence of): | Y JA | newy | | 56 | tayo |
| xaminer | | | b | Due to (| | | Y JA | aluy | <i>y</i> | 96 | taya |
| cal Examiner | Sequentially I | ist conditions, | b | Due to (d | or as a conseque | ence of): | V JA | <u> </u> | , | 96 | taya |
| edical | | ist conditions, to immediate Underlying se or injury wents | G | Due to (d | or as a conseque | ence of): | Y JA | alling | , | 96 | laye |
| edical | Sequentially I if any, leading cause. Enter Cause (Disea that initiated a | ist conditions, to immediate Underlying se or injury wents | c | Due to (d | or as a conseque | ence of): | V JA | alley | , | | lays |
| edical | Sequentially I if any, leading cause. Enter Cause (Disea that initiated e resulting in de | ist conditions, to immediate Underlying se or injury wents | c | Due to (d | or as a conseque | ence of): | | | | ontribute to the c | |
| Physician/Medical | Sequentially I if any, leading cause. Enter Cause (Disea that initiated e resulting in de | ist conditions, to immediate Underlying se or injury events seth) Last | c | Due to (d | or as a conseque or as a conseque or as a conseque | ence of): | | | tobacco use co | ontribute to the c | |
| by Physician/Medical | Sequentially I if any, leading cause. Enter Cause (Disea that initiated e resulting in de | ist conditions, to immediate Underlying se or injury events seth) Last | c | Due to (d | or as a conseque or as a conseque or as a conseque | ence of): | | 23b, Dfd 1 | tobecco use co | ontribute to the c 3 Probably 24b. Were autoravailable | ause of death? 4 Unknown topsy findings prior to on of cause |
| by Physician/Medical | Sequentially I if any, leading cause. Enter Cause (Disea that initiated e resulting in de | ist conditions, to immediate Underlying se or injury events seth) Last | c | Due to (d | or as a conseque or as a conseque or as a conseque | ence of): | | 23b, Dfd 1 | tobacco use co Yes 2 No an autopsy mmed? | ontribute to the c 3 Probably 24b. Were autavailable completic | ause of death? 4 Unknown topsy findings prior to on of cause |
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| o Be Completed by Physician/Medical | Sequentially I if any, leading cause. Enter Cause (Disea that initiated a resulting in de Part II. Other a 25. Was case examiner? 1 Yes 27. Manner of 1 Natura | ist conditions, to immediate Underlying se or injury wents sath) Last significant conditions of the co | Hospital: 1 Input | Due to (c Due to (c Due to (c Due to (c put not res pury any Year) | or as a consequence or as | ance of): | 28. Place of De ther: 4 Nursing to the state of the stat | 23b. Dfd 1 | tobacco use co | 24b. Were aut available complete of death? 1 Yes | ause of death? 4 Unknown topsy findings prior to on of cause |
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| Certification: To Be Completed by Physician/Medical | Sequentially I if any, leading cause. Enter Cause (Disea that initiated e resulting in de Part II. Other sexaminer? 1 Yes 25. Was case examiner? 1 Yes 27. Manner of 1 Naturs 2 Accid 3 Suicic 4 Homi | ist conditions, to immediate Underlying se or injury wents with Last selgnificant conditions with the conditions of the | Hospital: 1 Input 28a. Date of Inj (Month, De | Due to (c Due to (c Due to (c Due to (c) | or as a consequence of a consequence of as a consequence of a consequ | ance of): | 28. Place of De ther: 29. Place of De ther: | 23b. Dfd 1 | tobacco use co Yes 2 No an autopsy wmed? Yes 2 No one) dence 6 Ott how injury occur is street and Numi wn, State) cause(s) and m date end place, | 24b. Were aut available completic of death? 1 Yes her (Specify) med | ause of death? 4 Unknown topsy findings prior to on of cause 20 No |
| edical Certification: To Be Completed by Physician/Medical | Sequentially I if any, leading cause. Enter Cause (Disea that initiated a resulting in de Part II. Other sexaminer? 25. Was case examiner? 1 Natura 2 Accid 3 Suick 4 Homic | ist conditions, to immediate Underlying se or injury wents with Last selgnificant conditions with the conditions of the | Hospital: 1 Input 28a. Date of Inj (Month, De | Due to (c Due to (c Due to (c Due to (c) | or as a consequence of a consequence of as a consequence of a consequ | ance of): | 28. Place of De ther: 28. Nursing to xx at xx at xx at xx ime, dete end place opinion, deeth occu | 23b. Dfd 1 | tobacco use co Yes 2 No an autopsy wmed? Yes 2 No one) dence 6 Ott how injury occur is street and Numi wn, State) cause(s) and m date end place, | portribute to the c 3 Probably 24b. Were autorial available complete of death? 1 Yes ther (Specify) med ber or Rural Route canner as stated. and due to the complete of | ause of death? 4 Unknown topsy findings prior to on of cause 20 No |
| edical Certification: To Be Completed by Physician/Medical | Sequentially I if any, leading cause. Enter Cause (Disea that initiated e resulting in de Part II. Other sexaminer) 25. Was case examiner of 1 Nature 2 Accided 3 Suicided 4 Homical Homical Part II. September 1 | ist conditions, to immediate Underlying se or injury wents with Last selgnificant conditions with the conditions of the | Hospital: 1 Input 28a. Date of Inj (Month, De 28e. Place of In building, el Thysician: To the best miner: On the basis of and manner st | Due to (c Due to (c Due to (c Due to (c) Due to (c | DEP/Outpatient 28b. Time of Injury come, farm, streety) | ance of): | 28. Place of De ther: 29. Place of De ther: | 23b. Dfd 1 | tobacco use co Yes 2 No an autopsy med? Yes 2 No one) dence 6 Ott how injury occur Street and Numi wn, State) cause(s) and m date end place, 29d. Date signe | 24b. Were aut available completic of death? 1 Yes ther (Specify) med ber or Rural Route anner as stated. and due to the co | ause of death? 4 Unknown topsy findings prior to on of cause 20 No |

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Please Type or Print in Black indelible lnk. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend# 17 1/5/00 cmh AACO Health Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Dete of Death 3. Tima of Death Dev Month **Physician** J Eleanor 4b. City, Town, or Location of Deeth 4c. County of De 7:00am Atkinson /Medical 2000 4a Facility Nama (If not institution, give street end number) **Examiner** 6608 Grose Circle Elkridge Howard If Under 1 Year 5. Sociel Security Number 7. Aga (In yrs. last birthdey) Dete of Birth (Month, Dev. Year) Birthplace (State or Foreign Country) **Funeral** Hours 1 ■ M 2 □ F Months Deys 178-12-4777 81 Yrs Director 11/8/1918 Usual Rasidence of Decedent must be now 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director MD Howard Elkridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6608 Grose Circle 21075 Funeral 12. Wes Decedant Evar in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. filed within 72 hours after Yes 2 No If Yes, Give 1 ☐ Never Merried 2 ☐ Merried ъ altimore, Maryland 21215-0020 Specify: White 1□ Yes 2□No Specify: ğ 3 Widowed 4 □ Divorced Yaer or Detas: WWII Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygieno. Elamentery/Secondery (0-12) College (1-4or 5+) 4 Registered Dietitian Hospital 17. Father's Neme (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumama) permit. Pages 1 and 2 should be fit Department of Health and Mental Hy Important: If Nem 27 is marked oth any injury or other traumetic event Be Johnson Johnston James A. Anna May Whiteside 19a. Informent's Neme/Ralationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) Vint/ daughter 6608 Grose Circle Elkridge MD 21075

20b. Plece of Disposition (Name of Dete 20c. Location - City or Town, Stete Susan C. 20e. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 1 Surial 2 Cremetion 3 Removel from State 4 Donation 5 Other (Specify) Meadowridge Memorial 1/5/2000 Elkridge, MD 22. Name end Address of Fecility
Barranco & Sons, P.A. Severna Park FH 21. Signature of 5 neral Sporte Life 495 Ritchie Hwy Severna Park, MD 21146 Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart feiture. List only one causa on each line. Approximata interval Between Onset and Deeth **Physician** Chronic obstructive Lulmonary disease /Medical Immediete Ceuse (Final disease or condition resulting in daeth) Examiner Examiner Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or injury that initiated evants resulting in death) Last Due to (or es a consequença of): and P.O. Box 68760. The law requires that the death certificate be Physician/Medical the Due to (or es a consequance of): Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Pert f. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. þ sign 24b. Ware autopsy findings available prior to complation of cause of death? Be Completed 24a. Was an autopsy performed? 1 Yas 2 No 1 ☐ Yas 2 ☐ No certificate or Attanding Physician: funeral director, 25. Was casa referred to medical axaminer? 26. Placa of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No this 28a. Date of Injury (Month, Day Year) 27. Manper of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 | Natural 5 Pending Investigation death. 1 TYes 2 No 2 Accident 24 hours after deat Funeral Director: 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stata) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) completely filled in by 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion end/or invastigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) end menner steted. 29a. Certifier (Check only one) within 2 To the \$ 29b. Signatura and title of certifier 29c. License number 29d. Date aigned (Month, Day, Year) 2 2000

State Registrar

31. Date filed (Month, Dey, Year)

JAN 0 5 2000

ORAINE

8096 MD 32. Registrar's Signeture

30. Name and addrass of person who completed cause death (Item 23a) (Type, Print)

DAILE

EDWIN RAYNOR BLUB SUIKE

MD

21127

PASADENA.

JAN D.S. 2009 - November 2005 3 D MAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Deta of Death 3. Time of Death **Physician** Lucille W. Ansboro 2000 January 11:20 PM /Medical 4a Facility Neme (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel 8. Deta of Birth (Month, Day, Year) May 31, 1917 5. Social Security Number If Under 1 Yaar If Under 24 Hrs. Birthplace (State or Foreign Country)
 Ohio 7. Aga (In vrs. last birthday) Funeral 1 M 2 F Months Days Hours 283-09-6987 82 Yrs. Director Usual Residence of Decedent the Maryland 10a Stata 10h County 10c. City. Town or Location 10d. Inside City Limits "natural", or frame 23a or 28a-f show sitical Examiner must be notified at 1 ☐ Yas 2 No Directo Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 815 Chestnut Tree Drive 21401 USA death Funeral 12. Was Decedent Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☒ No If Yas, Give Year or Datas: 14. Race - American Indian, Bleck, Whita, atc. Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 11. Marital Status permit. Pages 1 and 2 should be filled within 72 hours after d. Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or hern any Injury or other traumatic event, the Health Exercises. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☒ No Specify: þ Specify: White 3 N Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Own home Homemaker 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George P. Weisbarth Anna O'Brien 19e. Informant's Name/Ralationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stephen E. Ansboro, Sr. / Son 933 Wells Ave. Annapolis, MD, 21403 20a. Mathod of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stata 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from Stata St. Mary's Cemetery 4 □ Donation 5 □ Other (Specify) 1-13-00 Annapolis, MD. 21. Signature of Funeral Sarvice Licensed 22. Name and Addrass of Facility John M. Taylor Funeral Home, Inc 147 Duke of Gloucester St. Annapolis, MD 21401 9 Man 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feilure. List only one ceuse on each line. Approximate Intervel Between Onset and Death **Physician** ANTERIOR MYOCAROIAL INFARCTIO /Medical Immediata Causa (Final ONE DAY diseasa or condition rasulting in death) Examine Physician/Medical Examiner physician and s the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Dua to (or as a consequence of) Box 68760. Due to (or as a consequance of): USB P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown HYPER GLYCEMIA Records, by 24b. Were autopsy findings available prior to completion of ceuse of death? Completed 24a. Was an autopsy performed? 1 Yas ZONO 1 Yas No Division of Vital or Attending Physician: 8 25. Was cese referred to medice! axaminar? 26. Place of Death (Check only one) To Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No 1) Inpatient 2 ER/Outpatient 3 DOA sinis funerai 27. Menner of Death 28b. Tima of 28d. Describe how injury occurred Certification: 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Affer 5 Pending invastigation NA 1 Yes 2 No 24 hours after death. Funeral Director: A 2 Accident 6 Could not be detarmined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 3 4 Homicide filled in Hospital Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and mannar as stated.

[In the discall Examiner: On the best of examinetion and/or invastigation, in my opinion, daath occurred at the time, data and place, and due to the cause(s) and mannar stated. edical 29a. Certifier (Check only one) within 2 the 29b. Signature and titla of certified 29c. License number 29d. Date signed (Month, Day, Year) D3903 1-09-00 DS MITCHELL 30. Nama and address of person who completed cause of deeth (Item 23a) (Type, Print) AAMC. DOUGLAS S MITCHELL ANNABLIS MO 21401

DHMH 16 Rev 6/95

State

Registrar

31. Date filed (Month, Day, Year)

JAN 1 1 2000

32. Registrar's Signatura

JAN 112000 Janes J. Frank

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3 Time of Death Elizabeth Neal Allen 9 2000 11:00 PM Jan 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Talbot Genesis Eldercare- The Pines Easton 5. Social Security Number 7. Age (In yrs. last birthday) if Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours Min 10 M 25 221-18-6673 Dec.30,1928 Maryland Usual Residence of Decedent 10h County 10c. City. Town or Location 10d. Inside City Limits Oueen Anne's Wye Mills 1 ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 14119 Old Wye Mills Road 21679 U.S.A. 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexicen, Puerto Rican, etc.) Bleck, White, etc. 1 ☐ Yes 2 ☐ No if Yes, Give X X Year or Detes: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: White 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Self Homemaker 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Edna Elizabeth Vickery Wingate Neal 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 14119 Old Wye Mills Rd., Wye Mills, Md. Thomas Allen (Husband) 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Locetion - City or Town, State Jan. 12, 2000 Buriai 2 Cremation 3 Removal from State Wye Mills, Md. Old Wye Church Cemetery 22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral HOme 23a. Parl. Enter the disease, or complications that russed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate shock, or heart failure. List only one cause on such line. Immediate Ceuse (Final diseese or condition resulting in death) CHRONIC RENAL FAILURE Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Last Due to (or es a consequence of): Due to (or as a consequence of) Part It. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown GANGRENE OF FOOT 24b. Were autopsy findings evalleble prior to 24a. Was en autopsy performed? completion of ceuse of death? 1 ☐ Yes 2 ☐ No

Physician /Medical **Examiner**

Physician

Examiner

Funeral

Director

tem 27 is marked other than "natural", or itema 23a or 28a-f show other treumatic event, the Medical Examinar must be notified at

permit. Pages 1 end 2 should be filed within 72 hours efter i Department of Health end Mentel Hygiene. Important: If Item 27 is marked other than "natural", or fler any Injury or other treumatic event.

Elizabeth Allen Baltimore, Maryland 21215-0020

the Menyland

/Medical

10e State

Md.

11

Director

Funeral

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Completed

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physician end s the buriel-trens 980

signed by certificate funeral

P.0.

Division of Vital Records.

Examiner Certification:

Physician/Medical þ Completed Be 0

Hospital or Attending Physician:
 24 hours after deeth.
 Funeral Director: After this certifice

Registrar

Medicai

DIAGETES MELLITUS PEMPHENAL VASCULAR DISCHES 25. Wes cese referred to medicel exeminer? 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other:

Mursing Home 5 ☐ Residence 8 ☐ Other (Specify) 27. Mapper of Deeth 28a. Date of Injury (Month, Dey Year) 28b. Time of Injury 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide 29a. Certifier

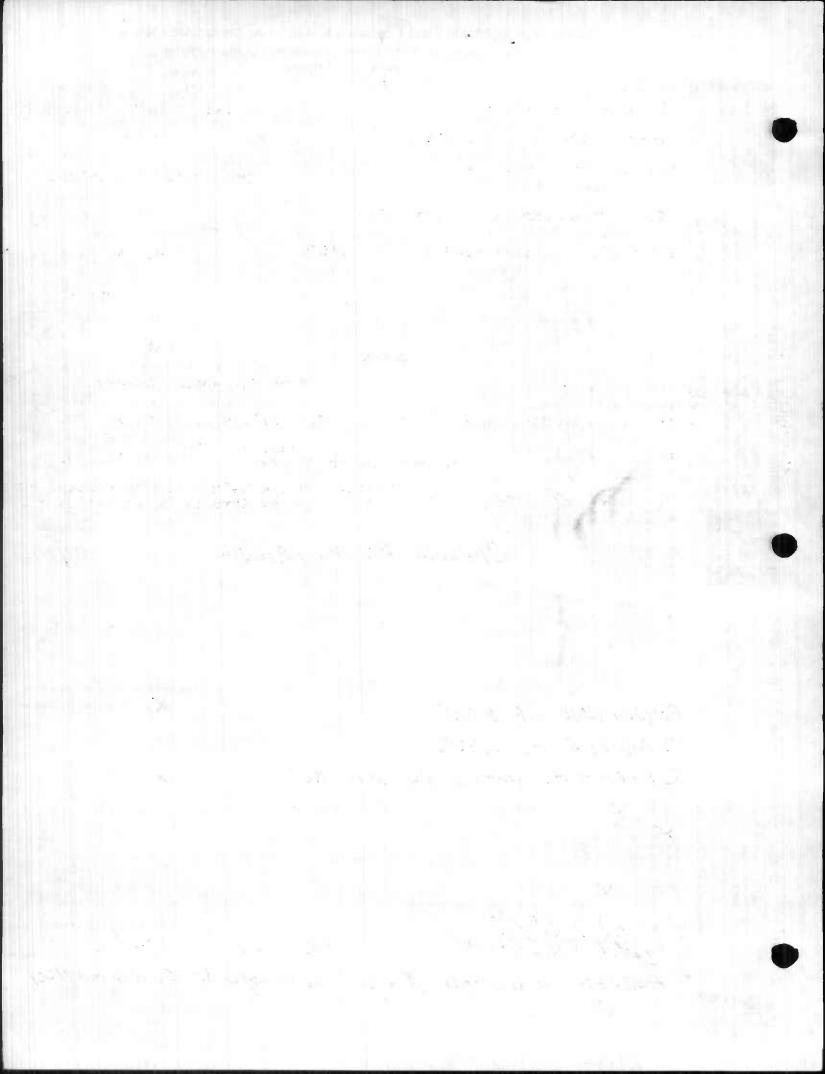
Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and piece, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end piece, end due to the cause(s) end manner stated. 29b. Signature and title of certile? 29d. Date signed (Month, Day, Year) 29c. License number

30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print)

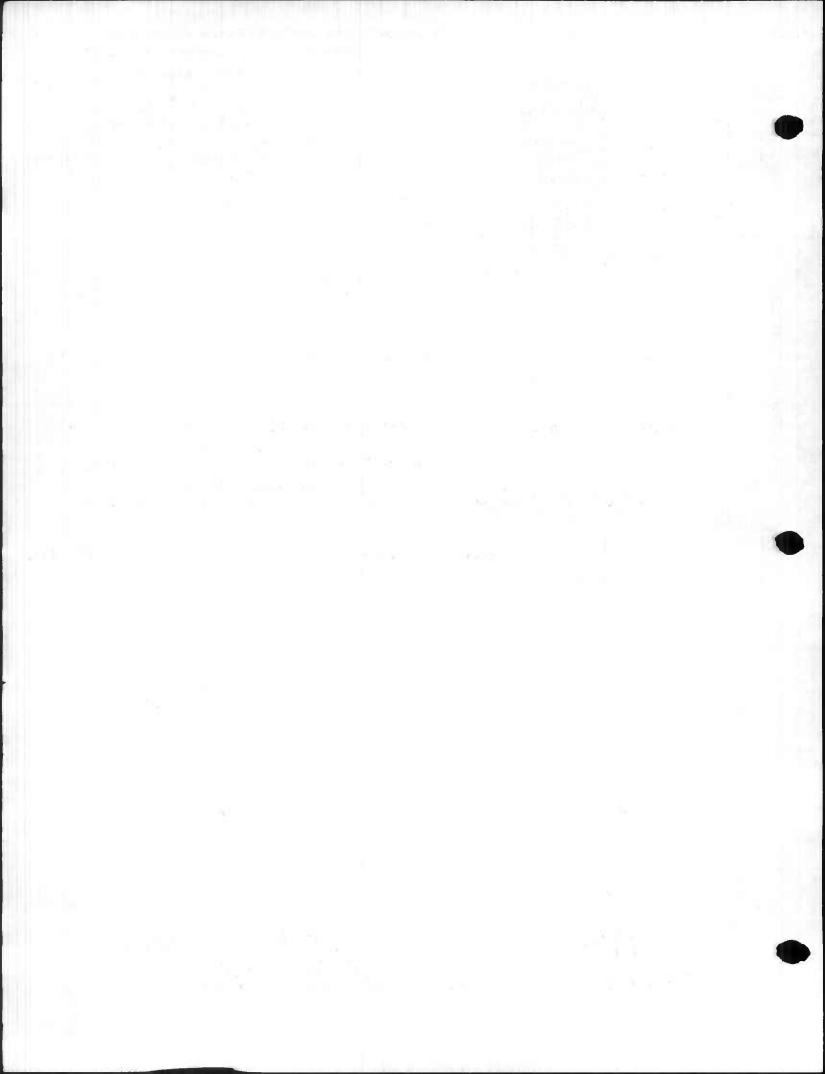
\$2195 Washington St Gaston mo 2/60/ mo 32. Registrar's Signature

To the I within 2 To the I



State of Maryland / Department of Health and Mental Hygiene

| | | | | | | Certi | ficate of | Death | | Reg. No. | 02 | 501 |
|---|---|---------------------|---|--|----------------|-----------------------------------|-------------------------------|---|---|--------------------------------------|--|----------------------------------|
| Di | hysici | 22 | 1. Decedent's Name (First, Middle, L. | ast) | | | | | 2. Date of Dea | ath Dey | Year 3 | 3. Time of Death |
| | /Medic | | Mary Elizabeth Ba | | | | | | Jan | 17 20 | | 8:25 AM |
| | xamir | | 4e. Facility Name (If not Institution, gi | ve street and number) | | | | 4b. City, Town, or | Location of Deeth | 4c. County | of Deeth | |
| | | | 23837 Bridgetown | Rd | | | | Henderso | n | Caro | line | |
| Fu | neral | | | Sex 7. Ag | je (In yrs. la | A | f Under 1 Year fonths Days | | | h v. Year) | 9. Birthplace Country) | e (Stele or Foreign |
| Din | ector | | 219 07 7060 Usuat Residence of Decedent | ППМ 20ДГ | 85 | Yrs. | | | Feb 9 1 | 914 | Mary1 | |
| Aaryland | ed at | or | 10a. State 10b. County | | | Town or Locat | ion | | | | | Inside City Limits |
| The A | E C | ect | Maryland Carolin | ne | Hend | lerson | 101 71 01 11 | | T | | | |
| £ 3 | 8 | 늅 | | | | | 10f. Zip Code | | | 10g. Citizen of V | what Country | / |
| the sea | 23 M | erai | 23937 Bridgetown | | C | 40.14 | 2164 | | | USA | | L . P |
| Z1Z15-UUZU d within 72 hours after death with the Manyand gigner. | marked other than hatterly, or nems 23a or 25a-2 anow imatic event, the Medical Examiner must be notified at | by Funeral Director | 11. Maritel Stetus 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced | 12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates: | | | es, specify Cub | | Specify Yes or No- rto Rican, etc.) | Specify | e - American ck, White, etc. whi | |
| 2-U | lical in | ted | 15. Decedent's E | ducation | | 16a. Deceden | t's Usual Occu | pation | a de la a | 16b. Kind of Bu | usiness/Indus | try |
| within ene. | Men | Completed | (Specify only highest gr Elementary/Secondary (0-12) | College (1-4or | 5+) | life. DO | NOT use retire | during most of wo | orking | | | |
| filled with Hygiene. | 1 | Con | 11 | | | machin | e opera | tor | | publi: | shing | company |
| D # f | Ven | Be (| 17. Father's Name (First, Middle, Las | 1) | | | | 18. Mother's Ne | me (First, Middle, | Meiden Sumem | 10) | |
| Maryland of 2 should be file lith and Mental Hy | atic . | To | Dennis M Hammett | | | | | Carri | e Mae Be | dford | | |
| | 1 | | 19a. Informant's Neme/Relationship | (Type, Print) | | 19b. Mailing A | Address (Stree | t end Number or F | Rural Route Numbe | er, City or Town, | Stete, Zip Co | de) |
| and and | er tr | | Thomas Baker sp | ouse | | 23837 | Bridge | town Rd | Henders | on, Mar | yland | 21640 |
| Dallimore, Semit. Pages 1 ar Department of Hea | a de | | 20e. Method of Disposition 1 ☐ Burial 2 X Cremation 3 [| Domousi from State | 20b. Pla | netery, cremet | on (Neme of | | Jan Date | 20c. Location - | City or Town, | State |
| Pag nent | n y | | 4 □ Donation 5 □ Other (Speci | | Ches | sapeake | Cremat | orv | - | Cheste | r. Mar | vland |
| permit. Pages 1 and 2 Department of Health a | any Inj | | 21. Signature of Funeral Service Lice | nsee | | 22. N | ame and Addre | ess of Facility | | | | / |
| 0 88E | E & 8 | | Atenda (| Fley | , | | | | ein Fune | | | |
| | | | 23e. Part1. Enter the disease, or con shock, or heart failure. List only | pticetions that caused | the deeth. | Do not enter t | he mode of dy | ng, such es cardia | sboro, M | aryland rest, | Ac | proximete |
| Physi | lclan | | snock, or near, failure. List only | one cause on eech II | ne. | | | | | | | ervat Between nset end Deeth |
| | dical | | Immediate Cause (Final | Down | + | ance | _ | | | | | 10 Whe |
| Exam | niner | | disease or condition resulting to death) | e. 10140 | | | | | | _ | | 10 413 |
| | | je l | | | D09 t0 (01 a | as a conseque | ice or). | | | | 1 | |
| pejn: | ansit | in i | Sequentially list conditions | b. ————— | Due to /or : | as a consequer | ace of). | | | | 1 | |
| 9 9 9 | rial-tr | EX | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury | | 000 10 (01 1 | as a consequen | 100 017. | | | | | |
| ficata be ex | e Dr | cai | thet initiated events | C | Due to (or a | is a consequer | ice of): | | | | | |
| tifica | as the burial-transit | Medical Examiner | resulting in death) Last | | | | | | | | | |
| ath cert | datached for use | 2 | | d | | | | | | · | | |
| deat of | D D | Physician | Part II. Other significant conditions | contributing to death b | ut not result | ing in the unde | rlvina cause di | ven in Part I | 23b. Did t | obacco use cor | ntributa to the | e cause of death? |
| at the de | tache | h | | | | | , | | | 108 2 NO | - | ly 4 Unknow |
| s tha | ab e | by F | | | | | - | | | | | , |
| necolds, F.C. BOX 00/00, he law requires that the death certificate be executed that been signed by the attending physician and | should be dat | | | | | | | | 24a. Wes | an autopsy | 24b. Were | autopsy findings ble prior to |
| | 2 sho | Completed | _ | | | | | | репо | med? | | etion of cause |
| C 0 F | 908 | E O | | | | | | | 1 🗆 Y | ea 2 No | | es 2 No |
| VILGIII Vician: Th | or, p | | 25. Was case referred to medicat | | | | | OR Piece of De | eath (Check only o | | 101 | 95 ZLI NO |
| Physician: | director, page | To Be | exeminer? | Hospital: | at 200 | R/Outpatient | 3□ DOA Oti | hor | Home 5 A Resid | | (0/4-1 | |
| Phys C | 7 | | 27. Menper of Death | 28a. Date of Inju (Month, De | | 8b. Time of | 28c. Inju Wo | | _ | ow injury occurr | | |
| Afe is | Į. | 를 달 | 1 Netural 5 Pending 2 Accident investigatio | | y Year) | Injury | | rk?]Yes 2 □ No | 7.50 D-41111 | | | |
| or Attending Physician: Tate death. Director: After this certificat | d in by the funera | Certification: | 3 ☐ Sutcide 6 ☐ Could not b | On Diana of Inc | ury - At hom | ie, farm, street, | factory, office | | | Street end Numb | er or Rurel Re | oute Number, |
| Tage 5 | i pe | Cert | 4 Homicide | building, et | с. (Specify) | | | | City or Tow | m, Stete) | | |
| To the Hospital or Att within 24 hours after of To the Funeral Direct | completaly filled | edicai | 29a. Certifier 1 Certifying Pt (Check only one) | nysician: To the best of miner: On the basis of and manner sta | examinetio | edge, deeth oc n end/or invest | curred at the ti | me, date end plec opinion, deeth occ | e, end due to the c urred at the time, | cause(s) and ma dete end plece, a | nner ss stete and due to the | d. e cause(s) |
| ithin of | dwo | Me | 29b. Signature and title of certifier | and mariner Sta | | | 29c. Licens | se number | | 29d. Date signed | d (Month. Des | r, Year) |
| ¥∓ | - 2 | | × XXXX | | | | - | 7887 | | . 1.01 | | |
| | | | UNIV | | | | | | 100 | 1/10/ | 00 | |
| | | | 30. Name and address of person who | completed cause of d | eath (Item 2 | | nt) Dr. | David 4 | SMITH | | | |
| | | • | 31 Date filed Worth Day | Wr. Su | ite J | 66 | ston | mu. | 21601 | | | |
| | Stat | le | 31. Date filed (Month, Day, Year) | nnn 32. Figura | ara Signatu | 9. | Anny 4 | 11 | | | | |



State of Maryland / Department of Health and Mental Hygiene amend item 23a,b,c,d per phys. G786 8/7/00 yg Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 11, 2000 10:43 PM RUSSELL S. BEITZEL JAN. /Medical 4b. City, Town, or Location of Death 4a Fecliity Name (If not institution, give street and number) 4c. County of Deeth Examiner CARROLL COUNTY GENERAL HOSPITAL WESTMINSTER CARROLL If Under 1 Yeer If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) **Funeral** Days 1 M 2 □ F **Director** 198-14-6210 12/28/1922 PENNSYLVANIA Usual Residence of Decedent the Maryland 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or itams 23s or 28s-f show the Medical Examiner must be notified at Yes 2 No MD. CARROLL WESTMINSTER Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? with 21 LONGWELL AVE. 21157 USA. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ∰ Yes 2 □ No if Yes, Give Year or Dates: ₩₩ II Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien. Biack, White, etc. 12 should be filed within 72 hours effer on and Mental Hygiene. It marked other than "natural" or fish 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: WHITE þ 3 ₩ Widowed 4 Divorced Completed 18a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done duning most of working life. DO NOT use retired) (Specify only highest grade completed) Coilege (1-4or 5+) Eiementary/Secondary (0-12) 12 MANUFACTURING DRAFTSMAN traumatic avent. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) RUSSELL ST.CLAIR BEITZEL Jean Mellinger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Heelth and Important: If Item 27 Ia m any Injury or other traum once. 138 LASSITER CIRCLE, FINKSBURG, MD. 21048 be of Disposition (Name of Dete 20c. Location - City or Town, Stete PATRICIA MURPHY 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State WESTMINSTER CEMETERY1/15/2000 WESTMINSTER, MD. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility FLETCHER FUNERAL HOME of Funeral Service Licenses 254 E. MAIN ST., WESTMINSTER, MD. 21157 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** /Medical immediate Cause (Final disease or condition resulting in death) is ease 100K Examiner Examine MULTIPLE PULMONARY EMBOLISM ongoing ician end bunal-trans Sequentially list conditions, if any, leading to immediate cause. Enfer Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequenca of): death certificate be exec 15yrs physician s the buria INTERSITIAL LUNG DISEASE Physician/Medicai Due to (or es e consequence of): as BRONCHIOHTIS OBLITERANS 1wk 950 P 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 1 Yee 2 No 3 Probably Wunknown Division of Vital Records. by 8 24b. Were autopsy findings aveilable prior to Completed 24e. Wes an eutopsy completion of cause of death? hes 1 Yes 2 No Yes 2 No Be 25. Was case referred to medical exeminer? 26. Piace of Death (Check only one) Hospital: 1 npatienf 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 20 No this funeral 27. Menner of Death 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? Certification: s ofter death.
I Director: After of in by the funer After 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide Hospital 24 hours 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end pieca, and due to the cause(s) end manner as stated. edicai 2 Medical Examiner: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. (Check only one) within 2 To the 29d. Date signed (Month, Day, Year) 29b. Signature and thip of cartifier 29c. License number January 12, 2000 44362 ENRICO A. GIANGERUSO 21157 30 Name and address of person who completed suse of death (Item 23a) (Type, Print) . , 200 Memoria Coun 31. Date filed (Month, Day, Year) Registrar's Signeture State JAN 1 4 2000 Registrar



the terms of the state of the second of the

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Dete of Deeth 3. Tima of Deeth Month Yaar **Physician** Oddery January 07:25 Brooks 2000 11 · /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, giva street and number, Examiner Baltimore Baltimore at If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) If Undar 1 Yaar 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foraign Country) 5. Social Sacurity Number 6. Sax **Funeral** 1925 West Virginia 1☑M 2□F Months Days 74 Yrs. 26, 727-01-3990 July Director Usual Rasidanca of Decedan the Maryland 10a Stata 10b. County 10c. City, Town or Location 10d. fnsida City Limits 7 is marked other than "natural", or items 23s or 28s-f show treumstic event, the Modical Examiner must be not that all 1 ☐ Yas 2 ☑ No Maryland Directo Carroll Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with United States 21157 1206 Nottingham Road death Funeral 12. Was Decedant Evar in U,S. Armed Forcas? 1 ⊠ Yes 2 □ No If Yas, Giva Yaar or Datas: WW II 14. Raca - American Indian, Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuben, Maxican, Puarto Rican, atc.) Black, Whita, atc. pernit. Pages 1 and 2 should be filed within 72 hours after to Deportment of Heelth and Mental Hygiene. Important: if item 77 is marked other than "natural", or item any injury or other traumatic event, the Modical Earn" as 1 □ Navar Married 2 □ Married Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: þ White 3 ☐ Widowad 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highast grada complated) Elementery/Secondary (0-12) College (1-4or 5+) Carpenter Self-employed 8th 18. Mother's Nama (First, Middla, Maidan Sumama) 17. Fathar's Nama (First, Middla, Last) Be Martha Rutherford Social B. Brooks 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Brother in Law Westminster, MD 21157 Calvin McKenzie 1206 Nottingham Road 20c. Location - City or Town, State West 20b. Placa of Disposition (Nama of cematary, cramatory or other placa) 20a. Mathod of Disposition 1 ☑ Burial 2 ☐ Cramation 3 ☑ Ramoval from Stata Blue Ridge Memorial Gardens 1/14/2000 Beckley, Virginia 4 ☐ Sonation 5 ☐ Othar (Specify) 22. Nama and Addrass of Facility
Burrier-Queen Funeral Directors, P.A. 21. Sign of Funeral Sarvice Licansee 1212 W. Old Liberty Road Winfield, MD 21784 mer 23a. Part. Enter the disaasa, or complications that caused the death. Do not antar tha moda of dying, such as cardiac or raspiratory arrest, show, or heart failura. List only ona causa on each line. Approximete Interval Between Onset and Daath **Physician** Immediata Ceuse (Final disaese or condition resulting in death) /Medical with Metastasis to Luna aningeal Examiner Due o (or as e consequanca of): Examiner physicien end the burial-transit certificate be executed Sequentially list conditions, if any, laading to Immadiata causa. Entar Undarlying Causa (Disaasa or Injury that Initiatad evants rasulting in daath) Last Dua to (or es e consequence of): Box 68760 Physician/Medical Dua to (or as a consaguanca of): 80 esn 23b. Did tobacco use contribute to the cause of death? ed by the detached Part II. Other stanificant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown neumonia g 24b. Wara autopsy findings available prior to complation of causa of death? Completed 24a. Wes an autopsy performed? peen has 1 Yas 2 LNG 1 Yas 2 ANO certificate Division of Vital Hospital or Attending Physicien:
 24 hours after death.
 Funeral Director: After this certific. director. 25. Was case refarred to medical Be 26. Place of Death (Check only one) axaminar? Othar: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Dimpatient 2 ER/Outpetient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 27. Mannar of Death 28b. Tima of 5 Pending investigation 1 Swatural 1 Yas 2 No 2 Accident 6 Could not be 3 Suicida 28f. Location (Streat and Number or Rural Routa Numbar, City or Town, Stata) 28a. Placa of Injury - At homa, farm, straat, factory, office building, atc. (Specify) in by 4 Homicida 29a. Cartifier 1 Contifying Physician: To the best of my knowledga, daath occurred at tha time, date and plece, and dua to tha causa(s) and mannar as stated Medical To the Hosp within 24 hor To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and mannar statad. 29c. Licansa number 29d. Data signed (Month, Dav. Year) 29b. Signatura and titla of cartifiar 30. Nama and addrass of person who completed causa of daath (Itam 23a) (Type, Print)

Baltimore, MD

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State

Registrar

A. Blattan

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Gwyneth A. B 31. Date filed (Month, Day, Year) 22

32. Registrar's Signatura

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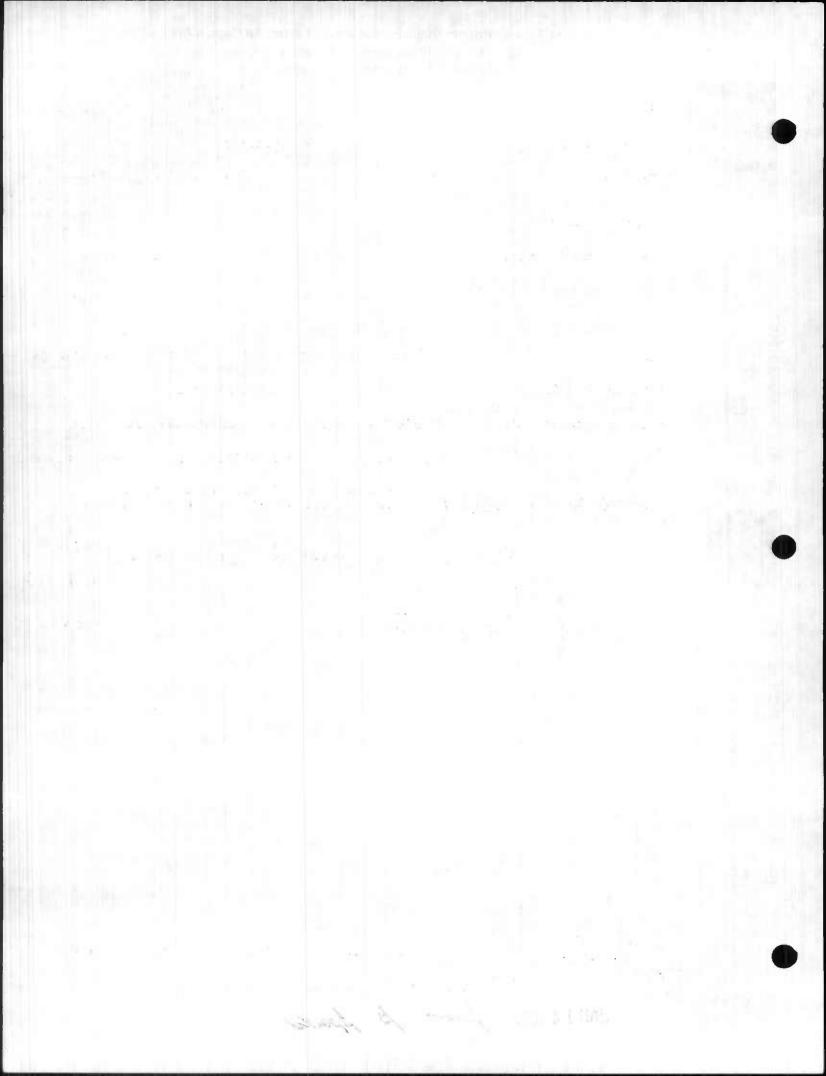
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State of Maryland / Department of Health and Mental Hygiefie

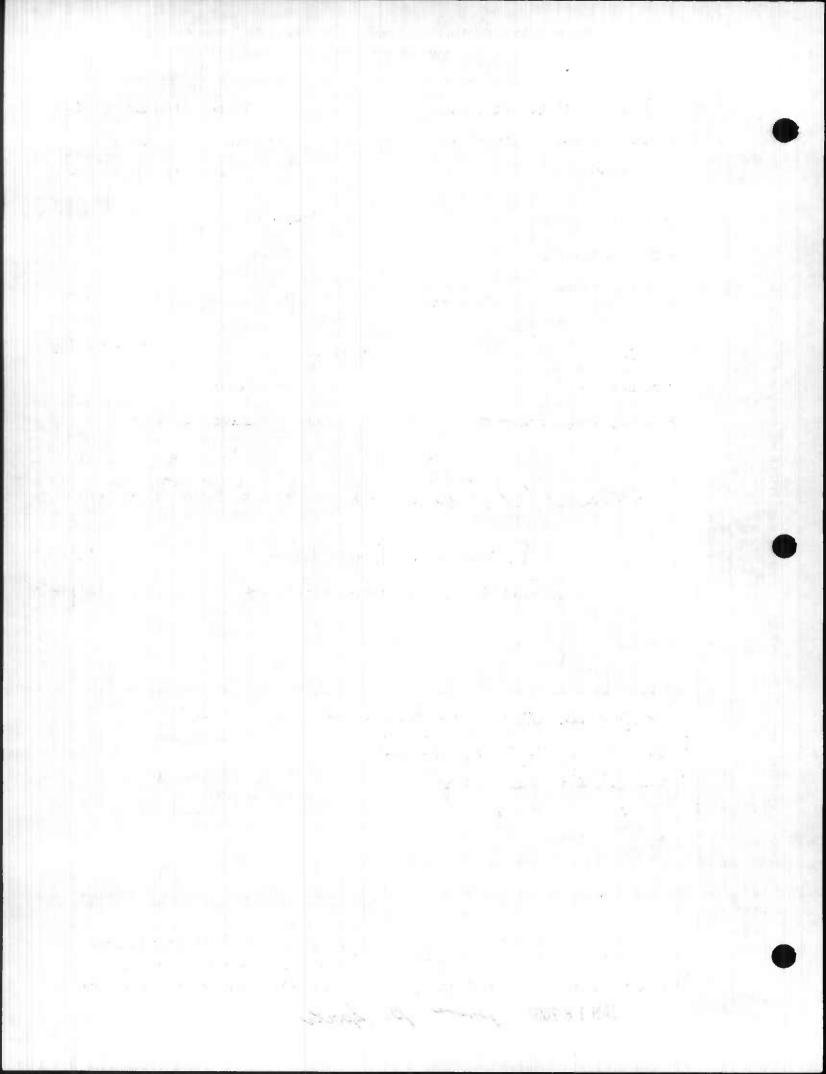
Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Tima of Death 2. Date of Death Month **Physician** 11 2000 2:15 PM Theresa Frances Bradford Jan. /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 834 Deer Ridge Drive Westminster Carroll If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year 7. Age (In yrs. lest birthdey) Birthplace (State or Foreign Country) **Funeral** Days Months 1 □ M 2 🔀 F Yrs. 214-01-2336 84 Feb 10, 1915 Maryland Director Usual Residence of Decedent with the Meryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show 1 ☐ Yes 2 No Director Maryland Carroll Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "naturel", or items 23s or 834 Deer Ridge Drive permit. Pages 1 and 2 should be filed within 72 hours after death v
Department of Health and Mentel Hygiene.
Important: If item 27 is marked other than "naturel", or items 23a
any injury or other traumatic event, the Medical 21158 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11, Marital Status Black White, etc. 1 Never Married 28 Married 1 ☐ Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Student Loan Department 12th Towson State College 18. Mother's Name (First, Middle, Meiden Surneme) 17. Father's Name (First, Middle, Last) Abraham Pennington Theresa Edler 19a. Informani's Name/Relationship (Type, Print) Husband 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Robert L. Bradford, Sr. 834 Deer Ridge Drive Westminster, MD 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Emory U.M. Church Cemetery 1/15/2000 Upperco, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature & Funeral Service Licenses Burrier-Queen Funeral Directors, P.A. ance 1 1212 W. Old Liberty Road Winfield, MD Do not enter the mode of dying, such as cardiac or respiratory arrest. 21784 P.nt1. Enfer the disease, or complications that ceused muck, or/heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** 12/18/99 Immediate Cause (Final disease or condition resulting in deeth) /Medical Arrest -Examiner to (or as a consequence of) 12/18/99 Examiner W 1 physician end the burial-transit The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or as a consequence of): xic CARS Box 68760. emm Physician/Medical Due to (or as a consequence of) 98 ettending s signed by the e 23b. Did tobacco use contributa to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. Division of Vital Records, P.O. 1 Yes 2 SNo 3 Probably 4 Unknown p 24b. Were autopsy findings available prior to completion of cause of death? should 24a. Was an autopsy Completed certificate hes t irector, pege 2 s 1 Yes 2 No 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours efter deeth.

To the Funeral Director: After this certific; completely filled in by the funeral director, Be 25. Was cese referred to medicel examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၀ 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? Certification: 5 Pending Investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide tel Certifying Phyalcian: To the best of my knowledge, death occurred at the time, date and plece, and due to the ceuse(s) end manner as stated.

2 Medical Examiner: On the bests of examination end/or investigation, in my opinion, death occurred at the time, dete and plece, and due to the cause(s) end manner steted. 29e. Certifier edical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 1000 brosten 1-0 30. Name and address of person who completed cause or death (Hem 23a) (Type, Print)
532 Battimore Blitt Sure 201
Westminster, Md. 21157 CHARLES M. HENGSEN, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 1 4 2000 Registrar



| | Decedant's Nama (First, Middla, Last, | | Ce | rtificate of | Death | 2. Data of De | Reg. No. | 1 | 3. Time of Death |
|---|--|---|---|--|--|---|-------------------------------------|-------------------------------------|--|
| Physiçian /Medical | John Bi | umber | ra | | | JAN | Day | Yaar OO() | 1824 |
| Examiner uneral | 4a Facility Nama (If not Institution, giva Carroll County 5. Social Security Number 136–34–4222 | General | (In yrs. last birthday) | 1 | Westmi. If Undar 24 Hr Hours Mir | s. 8. Data of Bir | Cath | 9. Birthple | ica (Stata or Foraigi |
| irector | Usual Rasidenca of Decedant | | 56 Yrs. | | | Jul 2 | 6,1943 | New | Jersey |
| show adat | 10a. Stata 10b. County Maryland Carro | 11 | 10c. City, Town or Lo | ocation | Hampste | ađ | | 10 | d. Inside City Limits 1 ☐ Yas 2 ☑ No |
| vat be notflied at ral Director | 10e. Street and Number | | | 10f. Zip Code | Tionipo co | uu | 10g. Citizen of V | Vhat Countr | y? |
| 23a o | 4000 Shiloh Avenu | е | | | 2107 | 4 | Ţ | JSA | |
| of, or items | 11. Marital Status 1 Nevar Marriad 2 Married 3 Widowed 4 Divorced | 12. Was Decedant E Armed Forces? 1♥ Yas 2 □ N If Yas, Giva Yaar or Datas: | 0 1/01/02 | Was Decedent of H If Yas, specify Cubin 1 ☐ Yes 2 ☒ No | lispanic Origin? (an, Maxican, Pua Specify: | Specify Yas or No rto Rican, atc.) | Specify | a - Amarica ck, Whita, a : Wi | |
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| other traumatic event, | 17. Fathar's Nama (First, Middla, Last) John Bumbera | | | | 18. Mothar's Na | ama (First, Middle e Coombs |), Me <i>id</i> an Sumam | 10) | |
| 7 is marked of traumatic eve To Be | 19a. Informent's Name/Reletionship (Ty Anne Lightbody, C | | | ng Addrass (Street) Shiloh | | | | | Coda) |
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| Important: if eny injury or ence. | 21. Signatura of Funeral Sarvice License | WE | | 2. Nama and Addra | ss of Facility | Eline St, Hamp | Funeral | Home | |
| ng physicien and as the bunel-transit | Sequentielly list conditiona, if any, laading to Immadiate causa. Enter Underlying Causa (Disaasa or injury that initiated avants rasulting in death) Last | Chron | Due to (or es a consecuent of | quence of): Au quenca of): | Pailur | E. | | | oyear |
| been signed by the ettending should be deteched for use as leted by Physician/Me | Pert II. Other eignificant conditions con | tributing to death bu | t not resulting in the u | indertying causa giv | van in Part t. | | | | the cause of death |
| an signed by ould be dete | Compresal 1 | board | and du | · sessi | | 24a. Was | yee 2□ No s an autopsy ormed? | 3 Prob | ably 4 Unknown ra autopsy findings liable prior to |
| page 2 | Cellestitie | Q 12 | Lox. | | 13. | 10 | Yes 2 No | of d | aplation of cause eath? |
| er this certificate leral director, pag n: To Be Co | 27. Mannar of Daath | lospital: 1 Inpatiar 28a. Data of Injun (Month, Day | y 28b. Tima o | nt 3 DOA | har: 4□ Nursing | eath (Check only Homa 5 ☐ Ras 28d. Describe | | |) |
| To the Funeral Director: After thi completely filled in by the funeral Medical Certification: 1 | 1 Netural 5 Pending 2 Accidant Invastigation 3 Suicida 6 Could not be datarmined | | ry - At homa, farm, st | M 1 | Yas 2□No | 28f. Location City or To | (Street and Numb wn, Steta) | ber of Rural | Routa Number, |
| pletely filled edical C | | | f my knowledge, deat examination and/or in tad. | | | | | | |
| To the | 29b. Signeture and title of cartifiar | . Gerl | on Tym | D 2 | sa number |) | 29d. Data signe | 2000 | |
| | 30. Nama and eddress of person who co | empleted cause of de | eath (Item 23a) (Type, | Print) 20 | 15 sto | iner Ai | mD #10 | 2115 | 5.7 |
| State Registrar | 31. Data tilad (Month, Day, Year) | 32. Ragistre | r's Signetura | / | | | | | |



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1 Decedent's Neme (First Middle Last) 3. Time of Death 2. Deta of Death Month **Physician** MARK RAY BITTINGER 2000 JANUARY 5:35 PM /Medical 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, give street end number) 4c. County of Death Examiner 633 COLUMBIA AVENUE CUMBERLAND
If Under 24 Hrs. | 8. Date ALLEGANY If Under 1 Yeer 8. Date of Birth Month, Day, Year) DEC 15 1971 5. Social Security Numbar 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 GM 2 □ F Months Deys Hours Min. MARYLAND 28 Yrs 218-78-6212 Director Usuel Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "naturel", or itema 23a or 28a-f ahow the Medical Examiner must be notified at No 2□ No CUMBERLAND Directo MARYLAND ALLEGANY 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21502 U.S.A. 633 COLUMBIA AVENUE permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene, important: if Item 27 is marked other than "natural", or Items 23a any Injury or other traumatic event, the Medical Examination 2006. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 24 No If Yes, Give Year or Detes: Wes Decedent of Hispanic Origin? (Specify Yas or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 11. Maritel Stetus 12 Never Merried 2 ☐ Married Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: WHITE by 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) UNEMPLOYABLE UNEMPLOYABLE 18. Mothar's Nama (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) DELORES EVERSOLE RAYMOND W. BITTINGER JR. 10 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Addrass (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 633 COLUMBIA AVENUE CUMBERLAND MARYLAND 21502 RAYMOND W. BITTINGER JR. FATHER Baltimore, 20b. Plece of Disposition (Neme of cemetery, crematory or other plece) 20a. Mathod of Disposition 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel trom Stete REST LAWN CEMETERY JAN 20 2000 LAVALE MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funerel Service Licensee 22. Name end Address of Fecility MERRITT-ADAMS FUNERAL HOME P.A. Sale L. Menut 404 DECATUR STREET CUMBERLAND MARYLAND 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or raspiretory arrest, shock, or heart feiture. List only one cause on each line. Approximata Intervel Between Onset and Deeth **Physician** Immediata Cause (Finel disease or condition resulting in death) /Medical CEREBRAL PALSY WITH COMPLICATIONS 28 YEARS Examiner Due to (or as e consequence of): Examiner certificate be executed physician and s the burial-trans Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disaase or Injury that initieted events resulting in death) Last Dua to (or es e consequence of): Box 68760. Physician/Medical Dua to (or as a consequence of). 98 980 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert f. P.O. the 1 Yes 2 No 3 Probably 4 Unknown signed by Records, by 2 24b. Were autopsy tindings available prior to completion of cause of death? 24e. Wes en eutopsy performed? Completed certificate has 1 ☐ Yes 2 ☐ No 2/No Division of Vital or Attending Physician: 25. Was casa ratarred to medical axaminar? Be 26. Place of Deeth (Check only one) 1 Yes 2 No Other: 4 Nursing Homa 5 Residence 6 Other (Specify) P 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Deta of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury et Work? Certification: After 1 Natural
2 Accident 5 Pending 1 ☐ Yes 2 ☐ No after death. investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, tarm, street, fectory, office building, atc. (Specify) 28t, Location (Street and Number or Rural Route Number, City or Town, Stata) 4 Homicida n 24 hou. Funeral D Hospital 29e. Certifier 1 Certifying Physician: To tha best of my knowledga, deeth occurred et the time, dete end place, end due to tha cause(s) and menner as steted. Medical To the Hosp within 24 ho To the Fune completely fi 2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date and plece, end dua to the cause(s) (Check only 29c. License number 29d. Dete signed (Month, Dey, Year) 29b. Signeture and title of certified 5 D 09159 JANUARY 17, 2000 30. Neme and eddress of purion who completed cause of deeth (Item 23a) (Type, Print) my DR PAUL SNOW 124 WEST 3rd STREET CUMBERLAND MARYLAND 31. Dete tiled (Month, Dey, Year) 32. Registrer's Signeture JAN 1 9 2000 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Clarence Levon Baker, Sr. January 12, 2000 10:05 AM /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4823 66th Avenue Hvattsville Prince George's If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 9. Birthplace (State Country)
November 10, 1941 Buffalo, NY 5. Sociel Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 10 M 2 F 065-32-9616 58 Vice Director Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at W Ves 2 No Director Maryland Prince George's Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4823 - 66th Avenue 20784 United States death v Funerai Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11 Marital Status filed within 72 hours after 1 Never Married 2 Merried 1 Yes 2 No If Yes, Give altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: à 3 Widowed 4 Divorced Yeer or Deles: Black Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) 12 years Private Carpenter permit. Peges 1 and 2 should be flie Department of Health and Mental Hy Important: If flem 27 Is marked other any Injury or other traumatic event onds. 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Lucille Life Nathan Baker 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 434 Winslow Avenue Buffalo, NY 14211 Clarence Baker, Jr. - Son 20b. Plece of Disposition (Name of cemetery, crematory or other plece) 20c. Location - City or Town, Stete 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Lee's Crematory 1/18/2000 Clinton, Maryland 21. Signature of Funeral Servica Lice 22. Name end Address of Fecility Stewart Funeral Home, Inc. 4001 Benning Road, N.E. Washington, D.C. 20019 er the disease or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, where failure. List only one cause on each line. Approximeta Intervel Between Onset and Deeth **Physician** JUNG CANCER /Medical Immediate Ceuse (Finel 6 Months disease or condition resulting in deeth) Examiner Dua to (or as a consequence of): Examiner certificate be executed Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury thal initiated events resulting in death) Last and the burial-tran Due to (or as e consequence of): Box 68760. Physician/Medicai Due to (or as e consequence of): 23b. Did tobacco use contribute to the cause of death? P.O. Pert II. Other algrifficant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed by t should be detach 1 PYas 2 No 3 Probably 4 Unknown Records, by 24b. Ware autopsy findings available prior to completion of cause of deeth? Be Completed 24a. Wes an autopsy page 2 s 1□ Yes 2₽No 1 Ves 2 No certificate Vital Hospital or Attending Physicien: 24 hours after death.
Funeral Director: After this certifica stely filled in by the funeral director, s 25. Wes case referred to medical 26. Piace of Deeth (Check only one) Hospitel: 1 ☐ Inpatient Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 2 ER/Outpatient 3 DOA Division of 28a. Dete of Injury (Month, Day Year) 27. Menneg of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Netural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 281. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral C completely filled 12 Certifying Physictan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner steted. 29e. Certifier 29b. Signeture and fitte of certifier 29c. License number 29d. Dete signed (Month, Day, Year) 241119 ajobl 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OR. #303 Rockville Md 20852

State Registrar 31. Date filed (Month, Dey, Year) JAN 1 4 2000

AYA SHARMA

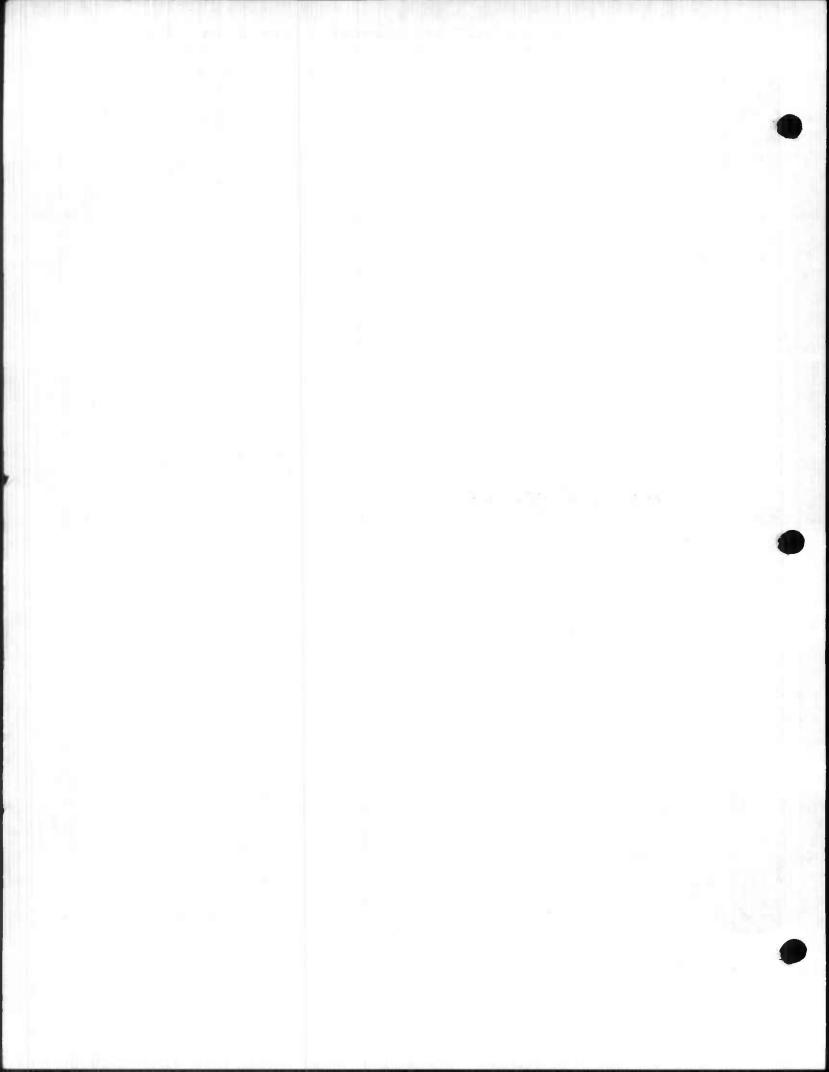
32. Registrer's Signeture

W. Edmonston

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State of Maryland / Department of Health and Mental Hygiene O

| | | | | | Certificate of | | | eg. No. | 02201 |
|--|---------------------|--|--|-----------------------------------|---|---|---|--|---|
| Physic | ian | Decedant's Nama (First, Middla, La | | | | | 2. Data of Death Month | h Day Yaar | 3. Tima of Death |
| /Med | | WILMER OLIN B | | | | | Jan. 5 | 2000 | 1:10 PM |
| Exami | ner | 4a. Facility Nama (If not institution, gin | and the second s | | | 4b. City, Town, or Lo | ocation of Death | 4c. County of De | ath |
| | | Memorial Hospit | al at Ea | ston | | Eastor | 1 | Talbo | ot |
| Funeral Director | | 217-36-0704 | Sax 7. Ag 1 ☑ M 2 ☐ F | a (In yrs. last bir 84 | thday) If Undar 1 Yaar Months Days | | 8. Data of Birth (Month, Day, | Year) 9. B 1915 Ma | Inhplaca (Stata or Foreign Country) |
| Pu | | Usual Rasidence of Decedant 10a, Stata 10b, County | | 10c. City, Town | or Location | | | | |
| aho a | 5 | 77.22.7 | Anne's | | treville | | | | 10d. inside City Limits |
| Ne N | Sct | | | CCII | | | | | 1 □ Yas AtNo |
| P & | - in | 10e. Street and Number | | | 10f. Zip Coda | | 10 | Og. Citizan of What C | Country? |
| ath v | rai | 614 Fogwell Ro | | | | 21617 | | U.S.A | |
| 11215-U020 within 72 hours effer death with the Meryland ene. than "natural", or items 23s or 28s-f show he Medical Examena must be notified. | by Funeral Director | 11. Marital Status 1 Nevar Married 2 Married 3 Widowad 4 Divorcad | 12. Was Dacedant Armed Forcas? 1 Yas 2 II If Yas, Give Yaar or Detes: | | 13. Was Dacedant of If Yas, specify Cub | | ecify Yas or No- Rican, atc.) | 14. Raca - Am Black, Wh Specify: Wh | |
| within 72 hc jene. r than "natur the Medical | Completed | 15. Decedant's E | ducation | 16a. | Decedant's Usual Occu (Giva kind of work done iifa. DO NOT usa retire | pation | 100 | 16b. Kind of Busines | s/Industry |
| within within ene. | pje | (Spacify only highast gra Elemantary/Secondary (0-12) | Collaga (1-4or 5 | +) | iifa. DO NOT usa retire | ed) | ing | Self-emp | loyed |
| | NO. | 7 | | | Farmer | | | Farmin | ıa _ |
| be filed had dother be other person, property person, pro | Be (| 17. Fathar's Nama (First, Middla, Last |) | | | 18. Mothar's Name | e (First, Middla, M | | |
| ylan ould be 1 Mentail mrked o | 10 | Wilmer Isaac E | lunt | | | Edna J | ewell | | |
| to the party | - | 19a. Informant's Name/Relationship (| Type, Print) | 19b | Mailing Address (Stree | and Number or Run | al Routa Number, | City or Town, Stata, | , Zip Code) |
| 5 5 E Z Z | | Mary Blunt (Wi | fe) | 61 | 4 Fogwell | Rd. Cen | trevil | le. Md. | 21617 |
| U | | 20a. Mathod of Disposition | | 20b. Placa of | Disposition (Nama of | T | | 20c. Location - City o | |
| DSILIMOTE, permit. Peges 1 are Department of Hear Important: if item: any injury or other once. | | 1 | y) | | y, crematory or othar pla erfield C | Jan. | 8,2000 | | lle, Md. |
| Demil Depart Impor any in | | 21. Signatura of Funaral Sarvice Licer | -/ | | erfield C 22. Nama and Addr Fellows, | II - 1 C 1 | 2 0 NY | - | |
| | | 23a. Part1. Enter the disease, or comshock, or heert failure. List only | plications that causad ona causa on each lin | tha daath. Do r | 1408 S. Li | iberty S | or raspiratory arra | ntrevill | Approximata Intarval Batween |
| Physician /Medical Examiner | er | Immediata Causa (Finel disease or condition rasulting in death) | alsh | limers | , | sta-en | / | | Onset and Death URMS |
| cate be executed physician end sthe buriel-transit | Examiner | Sequentially list conditions, | b. Dept | Dua to (or as a c | consequanca of): | | | | acys |
| rificate be executed ng physician end es the buriel-transit | cal E | Sequentially list conditions, if any, laading to Immadiate causa. Enter Undarlyling Causa (Oisease or injury that initialed avents | . Urinan | 1 tact | intecteux | | | | days |
| E 0.0 | Physician/Medical | rasulting in daath) Last | a hyper | Sua to (or as a c | | | | | years |
| eath cert ettendin | an | _ | 1 // | 1000,01 | | | | | yars |
| he e | Sic | Part II. Other significant conditions of | ontributing to death bu | it not rasulting in | tha undarlying causa gi | iven in Pert I. | 23b. Did tol | bacco use contribu | te to the cause of death? |
| es that the de igned by the | by Phy | diabetes 1 | nellitus | | | | 1 □ Ye | 2010 301 | Probably 4 Unknown |
| aw requires been size should | Completed I | _ diobetes i _ peripheral | vascy lar | disca | 350 | | 24a. Was er perform | | Ware autopsy findings available prior to completion of cause of deeth? |
| | ပ္ပို | | | | | | 1 □ Ya | s 2 13-140 | 1 ☐ Yas 2 ☐ No |
| ysician: The s certificate director, pag | Be | 25. Wes casa rafarred to medical axaminar? | | | | 26. Piece of Deat | h (Check only one | a) | |
| . 2 00 10 | 2 | 1 Yas 2 No | Hospital: 1 ☐ Inpatia | nt 2 ER/Out | patient 3 DOA | her: 4 Nursing Ho | ma 5 🗆 Rasidar | nca 6 Other (Sp | pecify) |
| 5 5 5 | | 27. Manner of Death 1 Natural 5 Pending 2 Accidant invastigation | 28a. Deta of Injur (Month, Da) | y Year) 28b. T | njury Wo | rry at ork?] Yas 2 □ No | 28d. Dascribe ho | w Injury occurred | |
| To the Hospital or Attending within 24 hours effer death. To the Funeral Director: Affair completely filled in by the fune | Certification: | 3 Sulcida 6 Could not b datarmined | 28a. Place of Injubuilding, atc | iry - At homa, fai . (Spacify) | m, straat, factory, office | | 28f. Location (Str. City or Town, | reet and Number or I , Stata) | Rural Routa Number, |
| Hospit 24 hours Funeral letely fille | edical (| 29a. Cartifler (Check only one) | yelclan: To the best on the sails of and mannar sta | axamination and | deeth occurred at tha ti | ima, deta end plece, opinion, daath occurr | and dua to the ce ed at tha tima, da | use(s) and mannar a ita and place, and du | as stated. ua to tha cause(s) |
| o thin o the | Me | 29b. Signatura and title of certifier | | | 29c. Lican | sa number | 29 | d. Data signed (Mor | nth, Day, Year) |
| F 5 F 0 | | * dille | Klose | / | | | | Jan. 6,2 | |
| | | MARIEL | Toury | | | 7627 | | , uii. 0, 2 | |
| | | 30. Name and addrass of person who | | | | | | | |
| | | Kathleen Hoey, | | | creville i | Rd., Cent | reville | , Md. 2 | 1617 |
| Sta Registi | | 31. Dete filed (Month, Day, Year) JAN 1 3 | | r's Signatura | B. Spa | s May | | | |



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Deta of Death Day 09, Yes 2000 Month **Physician** 10 Am Johnny Shepherd Brown, Jr. January /Medical 4b. City, Town, or Location of Death 4c. County of Death 4e Facility Neme (If not institution, give street and number) Examiner Lanham Prince George's Doctor's Hospital 8. Date of Birth (Month, Dey, Year)
Jan. 3, 1945 If Under 24 Hrs. 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) 9. Birthplaca (State or Foreign Funeral Days Months Hours 1X M 2 F 55 Washington, DC Yrs. 578-58-3520 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits V Yas 2□No Maryland Upper Marlboro Directo Prince George's 10e. Street end Number 10f. Zio Code 10g. Citizen of What Country? 10542 Joyceton Drive 20774 USA Funeral 12. Was Decedent Evar in U.S. Acreed Forces? 1/EMYes 2□No Army If Yes, Give Yeer or Detas:1966-68 Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Maritel Status Bleck, White, etc. 1 Naver Married 2 Merried 1 Yes 2 No Specify: Black. Specify. by 3 Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) 12th College (1-4or 5+) Custodial/Maintenance Engineer US Postal Svc- Govt. 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Johnny S. Brown, Sr. Nannie Robinson 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10542 Joyceton Drive Upper Marlboro, MD 20774 Dorothy Bell/ Companion 20b. Piece of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Buriei 2 ☐ Cramation 3 ☐ Removel from Stete 1-14-00 Laurel, Maryland Maryland National Cem. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name end Address of Facility Marshall's Funeral Home of Md Suitland, Maryland 20746 4308 Suitland Rd. 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximate Intervat Between Onset and Death **Physician** Metastate Hypothe Cancenoma /Medical tmmediate Cause (Finel disease or condition resulting in deeth) Examiner Examiner Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequence of): Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Dtd tobacco use contribute to the cause of death? 1 Yaa 2 No 3 Probably 4 Unknown Completed by 24b. Ware autopsy findings available prior to 24a. Wes an eutopsy performed? completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Wes case referred to medical axaminer? 26. Placa of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Impatient 2 ER/Outpatient 3 DOA 28e. Dete of Injury (Month, Day Year) 28b. Time of Injury 27. Menner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 2 Accident 6 Could not be determined 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 Homicide 1 Cartifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) 29a. Certifier Medical (Check only one) end menner steted. 29d. Date signed (Month, Day, Year) 29b. Signetura en title of certifiar 29c. License number

24 hours a completely within 2 ŝ 0

Pages 1 and 2 should be nent of Health and Mental

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Box 68760

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Division

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State Registrar 31. Dete filed (Month, Day, Year) JAN 1 3 2000

30. Nama and address of person who

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10274 Me An Bon un \$202 Autolibrille (us. 2012) Mekon 32. Registrer's Signeture

impleted cause of deeth (item 23a) (Type, Print)

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JAM 1 3 2888

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 0 2211

| | | | | | (| Certifica | ate of | Death | | | Reg. No. | U | 66 | |
|--|--------------------|--|---|-----------------------------------|---------------------------|-------------------------------|--------------------------|------------------------------|-------------------------|--|------------------------------|---|--|---------------------|
| Dhuaiai | | 1. Decedent's Nama (First, Middle, L | | | | | | | | 2. Data of De Month | Day | Year | | e of Death |
| Physici /Medic | | ANDERSON THOM | | | ₹. | | | | | January | | 2000 | 2:29 | PM |
| Examin | er | 4a Facility Name (If not institution, g Southern Marylar | | | nter | | | Clint | on | cation of Death | | nty of Death ce Geo | | |
| Funeral Director | | 228-07-5309 | Sex 11 M 2□ F | 7. Age (In yrs | 93 Yr | Bands | der 1 Year ns Days | | 24 Hrs. Min. | 8. Data of Bir (Month, Da June I | , 19 06 | | place (State) inity) inia | ta or Foreign |
| P . | | Usual Residence of Decedent 10a. State 10b. County | | 10c. C | ity. Town o | or Location | | | | | | | 10d Inside | e City Limits |
| with the Maryland a or 28s-f show the notified at | ctor | Maryland Prince | Georges | | | Hills | | | | | | | 15/1 | ′as 2□No |
| £ 8 | Funeral Directo | 10e. Street and Number 6504 Roberts Dri | .ve | | | 10f. | Zip Code | 20748 | | | 10g. Citizen U.S | | intry? | |
| 5-0020 72 hours after death in natural; or from 23 | by | 11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced | 12. Was Deced Armed For 1 Yes If Yes, Give Year or Da | ces? 2 No | U,S. | If Yes, s | cedent of pecify Cut | an, Mexican | gin? (Spe i, Puerto | ecify Yas or No Rican, atc.) | | Race - Amar Black, White Blacify: Bla | , atc. | J _e |
| 15-00: | e e | 15. Decedent's (Specify only highest g | | | 10 | ecedent's U Give kind of | work done | during most | t of worki | ing | 16b. Kind o | f Businass/I | ndustry | |
| 2121 d within glene. | Completed | Elementary/Secondary (0-12) | College (1- | 4or 5+) | Labo | la. DO NO | use retin | ed) | | | Norfo | lk Nav | al Ba | ase |
| Maryland 21215-0020 d 2 should be filed within 72 hours at a 2 should be filed within 72 hours at 7 is marked other than "natural", or traumatic event, to a send of the marked other than "natural", or traumatic event, to | To Be C | 17. Father's Name (First, Middle, Las Cornelius Buck | | | | | | | | (First, Middle, | | name) | | |
| ary and N | | 19a. Informant's Name/Relationship | (Type, Print) | | 19b. k | Mailing Addr | ess (Stree | t and Numbe | or Aura | al Routa Numb | er, City or To | wn, State, Zi | ip Code) | |
| ond 2 | | Harrison Buck - | Son | | 650 | 04 Rob | erts | Drive | , Te | emple H | ills, | MD 207 | 48 | |
| Baltimore, semit. Peges 1 el pertinent of Hee mportant: If Hem. inty Injury or otherane. | | 20a. Method of Disposition 1 🖾 Burial 2 Cremation 3 4 Donation 5 Other (Spec | | itate | cemetery, | crematory of | r other ple | church | Col | Data -10-00 | | on - City or T | | |
| Baltimore, Maryland 2121 pernit. Pages 1 and 2 should be filed within 1 Department of Health and Mental Hygiens, Important: If item 27 is marked other than 7 any injury or other traumstic event, the 11-11 | | 21. Signature of Funeral Service Lic | | 00 | perry | 22. Name Mar | and Addr | ess of Facility 1 's Fu | nera | 1 Home | | on DC | 2001 | 1 |
| Physician /Medical Examiner | Iner | 23a Part1. Enter the disease, or co- stock, or heart failure. List onl Immediate Cause (Finat disease or condition resulting in death) | . Ventri | cular Due to | Arrhy | ythmia | | | | | | | | Batween nd Death |
| 876 ete be hysicie | n/Medical Examiner | Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | c. Cancer | of Pr | orasa con Costa | nsequence o | | | | | | | Ū. | |
| deeth deform | Solo | Part It, Other significant conditions | contributing to dea | ath but not re | sulting in t | ne underlvin | o causa o | iven in Part I. | | 23b. Did | tobacco usa | contribute | to the cau | as of death? |
| that the d | by Physician/ | | | | | | | | | 10 | Yes 2 N | lo 3 Pro | obably 4 | I □ Unknown |
| Records, P.O. Box 6 he lew requires that the deeth certific electron signed by the ettending page 2 should be deteched for use as | Completed b | | | | | | | | | | an autopsy rmed? | a | Vera autopolivaliable pri completion of death? | ior to |
| f Vital Reysiden: The lev | 5 | | | | | | | | | 10 | Yas 2⊠N | 0 1 | ☐ Yas 2 | 2□ No |
| /Ita | 8 | 25. Was case referred to medicat examiner? | | | | | | | of Deet | h (Check only o | one) | | | |
| - S O | 2 | 1 Yes 2 No | | | 1 | atient 3 | DUA | | | me 5□ Resi | | | ity) | |
| DIVISION OF A STANDARD PROPERTY OF THE CONTROL OF T | Certification: | 27. Manner of Death 1 🖾 Natural 2 Accident investigati 3 Suicide 6 Could not | | trijury i, Day Year) | 28b. Tin | | 28c. tnju Wo 1 | iry at ork?]Yes 2 ☐ I | No | 28d. Describe | | | | |
| DIVISION O To the Hoaptal or Attending Ph Within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral | Certif | 4 Homicide determine | 1 288. Place (| of Injury - At I g, etc. (Spec | home, farm | , street, fac | ory, office | | | 28f. Location (: City or To | | imber or Ru | ral Routa N | lumber, |
| Ne Hoep n 24 hou Ne Funel pletely fil | edical | 29a. Certifier (Check only of Medical Exp | hysician: To the b miner: On the bas and manne | sis of examin | owledge, d ation and/o | leath occum or investigati | ed at the t on, in my | ima, data and opinion, deal | d place, a th occurr | and due to the ed at tha time, | cause(s) and date and pla | mannar as ce, and due | stated. to the caus | ie(s) |
| To the To the comp | ž | 29b. Signature and Ittle of certifier | hu | RT | 1 | | | se number | | | 29d. Data sig | | | |
| (5) | | 30. Name and address of person who | | | | | D-2. | | | | | | | |
| | | BAHRAM PISHDAD, I | | Sout | | Ave., | S.E. | Suite | e 310 | O Washi | ngton, | D.C. | 2003 | 2 |
| Stat | e | JAN 1 2 2000 | Z | ground o Sign | 6 | 1 | | , | | | | | | |

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** William Truxton 7, 2000 4:38 pm Bowers, Sr. January /Medical 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Takoma Park Montgomery If Under 24 Hrs. If Under 1 Yeer 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Deys Hours Months 1 M 2 F 579-07-1537 81 July 16, 1918 Director Washington, DC Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a, Stete 10b. County 10d. Inside City Limits must be notified at 1 No Yes 2 No Directo Maryland Prince George's Chever1v 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 20785 3008 Crest Avenue U.S.A. Herra 23a Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Merital Status 12. Was Decedent Ever in U,S. Armed Forces? Black, White, etc. at Hyglane. Other than "natural", or fler 1 ☐ Never Married 2 Married 1 ⊠ Yes 2 □ No If Yes, Give Year or Detes: 1944-46 Raltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Insurance Agent Department of Health and Zehould be file be bearing the bearing them 27 is marked other only injury or other traumatic event, once. 18. Mother's Name (First, Middle, Maiden Sumame) 17 Father's Name (First Middle Last) Be Aloysius R. Bowers Madeline Collins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Elizabeth Bowers - Wife 3008 Crest Avenue, Cheverly, Maryland 20785 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery 01/11/00 Brentwood, Maryland 21. Signature of Funeral Service Licensee 22. Neme and Address of Facility Gasch's Funeral Home, P.A. 7.1 Constance Jasa 4739 Baltimore Avenue, Hyattsville, MD 20781 23a. Part1. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in deeth) /Medical Recurrent Ventricular Fibrillation Examiner Due to (or as a consequence of): Examiner Acute Myocardial Infarction burial-tran Sequentielly list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury and Due to (or as a consequence of): Box 68760. physician cartificata be Physician/Medical the that initiated events resulting in death) Last Due to (or as e consequence of): 85 050 ö 23b. Did tobecco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 100 signed by t 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, p The law requires 24b. Were autopsy findings aveilable prior to should I Completed 24a. Was en autopsy completion of cause of death? Sec 1 Yes 2 No 1 ☐ Yes 2 ☐ No of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospifal: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No To this funaral 27. Menner of Death 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: Aftar 5 Pending investigation Division the Hospital or Attending 1 Natural s after death.

I Director: Aft
od in by the fur 1 TYes 2 □ No 2 Accident 6 Could not be determined 3 Sulcide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building etc. (Specify) 4 Homicide within 24 hours a To the Funeral C 12 Certifying Physician: To the vest of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and manner as stated.
2 Medical Staminer: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier Medical npletaly (Check only one) 2 Medical Exa 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture and title of certifier D22639 January 9, 2000 30. Name and address of adrson who completed ceuse of death (Item 23a) (Type, Print)

State Registrar

DHMH 16 Ray 6/95

7600 Carroll Avenue, Takoma Park, Maryland 20912

M.D

32. Regisfrar's Signature

Fayaz A. Shawl, 31. Date filed (Month, Dey, Year)

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JAN 1

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3 Time of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death Month 05 Az 2000 Sarah R. Bacher en 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not Institution, give street and number) Greater Washington The Hebrew Home of Montgomery Rockville 7. Aga (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Birthplaca (Stata or Foraign Country) 5. Social Sacurity Number 6. Sax 8. Data of Birth (Month, Day, Year) 1 M 2 TF Yrs 102 578-26-4632 Nov. 27, 1897 Romania Usual Rasidenca of Decedent 10a. Stata 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 AYas 2 No Maryland Montgomery Rockville 10g. Citizan of What Country? 10e. Street and Number 10f. Zip Coda 6121 Montrose Rd. 20852 United States 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 12. Was Decedant Evar in U,S. Armed Forcas? 11. Marital Status 1 Yas 2 No If Yas, Giva Yaar or Datas: 1 Navar Married 2 Married 1 Yas & No Specify 3√2 Widowed 4 □ Divorced White 15. Decedant's Education (Specify only highast grada complated) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Collaga (1-4or 5+) 6 Fur Finisher Retail Clothing 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Surnama) Solomon Riemer Fruma (Unknown) 19a. Informant's Name/Ralationship (Type, Print) 19b. Maiting Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Ethel Chack/Daughter 8404 Ellingson Dr. Chevy Chase, MD. 20815 20b. Placa of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition Burial 2 Cramation 3 Ramoval from State 4 Donation 5 Other (Spagety) 01/09 Elesavetrograd Cem. Washington, DC. 21. Signature of Europh Service Via 22. Nama and Addrass of Facility Takoma Funeral Home. Local Paragraphications that causad the death. Do not antar the mode of dying, such as cardiac or respiratory arrest, failure. List only one cause on each line. 254 Carroll St. NW. Washington, DC.20012 Approximata Intarval Between Onsat and Death Immediata Causa (Final disaasa or condition rasulting in daath) acute Dua to (or as a consequence of) Covonany Sequantially list conditions, if any, laading to immadiata causa. Entar Underlying Causa (Disaasa or Injury that initiated avants rasulting in daath) Last Dua to (or as a consequence of): neumonia Dua to (of as a consequence of): 23h. Did tohacco use contribute to the cause of death? 1 Yes 2 No 3 Probably T Unknown 15chemia 24b. Wara autopsy findings availabla prior to completion of causa of daath? 24a. Was an autopsy performed? 1 Yas 2 No 26. Placa of Death (Check only ona) Hospital: Othar: Nursing Homa 5 Rasidanca 6 Othar (Specify) 1 Inpatiant 2 ER/Outpatient 3 DOA 28d. Dascribe how Injury occurred 28b. Time of 28c. Injury at Work?

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Physician

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| Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signatura and titla of certifiar

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29d. Data signed (Month, Day, Year)

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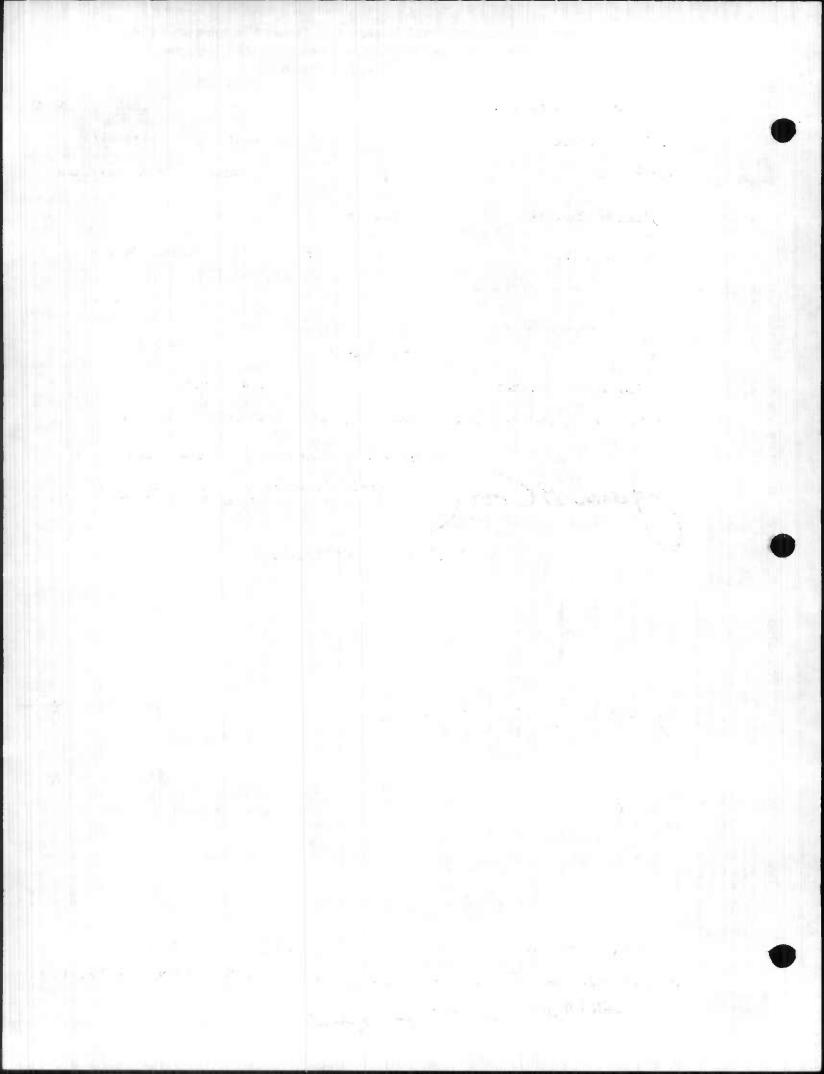
State of Maryland / Department of Health and Mental Hygiene

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Sharing St. - I DODS I CHAIL

Amended Item #23b, Per Phy., 01/10/2000, Carroll County, cew Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Tima of Death Month **Physician** 3:30 AM Charles Leo Buckman 9 2000 Jan. /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Carroll Westminster 2301 Ridge Road If Under 1 Yeer | If Under 24 Hrs. Birthplaca (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. last birthdey) 8. Dete of Birth (Month, Day, Year) **Funeral** 1☑ M 2□ F Months Days Hours 85 Yrs. 218-09-3805 June 27, 1914 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits Item 27 is marked other than "naturel", or items 23s or 28s-f show other treumstic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Westminster Carroll Maryland Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 21157 2301 Ridge Road Funeral death 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Meritei Status Black, White, atc. permit. Pages 1 end 2 should be filed within 72 hours after or Department of Health end Mental Hygiena. Important: If Item 27 is marked other than "naturel", or Item 1 □ Never Married 2 □ Married altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White p 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highest grade completed) Elamantary/Secondary (0-12) College (1-4or 5+) MD Dry Dock Pipe Fitter 12th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Nora Gilbert Charles P. Buckman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. informant's Name/Ralationship (Type, Print) 1329 Ridge Road Westminster, MD Charles Wesley Buckman Son 20b. Place of Disposition (Name of cemetery, crematory or other plece) 20a. Mathod of Disposition Dete 20c. Location - City or Town, State any injury or o 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Jennings Chapel Cemetery 1/12/2000 Lisbon, MD 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility
Burrier-Queen Funeral Directors, P.A. 21. Signature of Funaral Sarvice Licensae 1212 W. Old Liberty Road Winfield, MD 21784 Part 1/Enter the disease, or complications that cause all shock, or heart failure. List only one cause on each Approximeta Intarval Batween Onset and Death Do not enter the mode of dylng, such as cerdiac or raspiratory arrest, **Physician** /Medical Immediata Cause (Final disease or condition resulting in death) Examiner Examiner physician and the burial-tran Sequantially list conditions, if any, laading to immediate ceuse. Entar Underlying Cause (Disease or Injury that initiated events resulting in daath) Last Due to (or as a consequence of): requires that the death certificate be exec Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequenca of): SE 950 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 Yes 2 No 3 Probably 4 Unkr disease Completed by 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? has 1 ☐ Yes 2 No certificate or Attending Physician: Be 25. Was cese raferrad to medical examiner? 26. Placa of Death (Check only one) Other: 4 ☐ Nursing Home 5 Residenca 6 ☐ Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 5 Pending after deeth. 1 ☐ Yes 2 ☐ No Investigation 2 Accidant 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) and mannar as stated.
2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, daath occurred at tha time, date and place, and due to the cause(s) and manner stated. edicai 29a. Certifier (Check only one) within 2 the 29c. License number 29d. Dete signed (Month, Day, Year) 29b. Signatura and title of certifier 51705 1-10-2000 westminster moalist. 30. Name and address of person who completed ceusa of death (Item 23a) (Type, Print) malw/m DR, M. PANSURIYA, MD 419F JAN 10 2000 31. Data filed (Mor 32. Registrar's Signatura State Registrar



Please Type or Print In Black indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle: Last) Month **Physician** 10:05am Jan 2000 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner HOSPITA HOWARD OUNTY GENERAL olumbi a TOWARD If Under 1 Year | If Under 24 Hrs. 9. Birthplaca (State or Foreign Country)
Washington 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Aga (In yrs. last birthday) **Funeral** Days 15M 20 F 216-40-5459 Yrs. **Director** 25,1942 June Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryten. Department of Health and Mantal Hygiena. Important: If item 27 is marked other than "naturel", or frame 23s or 28s-f show any injury or other traumatic event, it a Mod cal Examine mail be notified as 1 ☐ Yas 2 ☐ No Director Howard Ellicott City 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 12244 Pointer Hill Court 21042-1339 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yas, Give Yaar or Dates: 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0020 White 1 Yes 2 No Specify: Specify P 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Computer Engineer Transportation 17. Fathar's Neme (First, Middle, Last) 18. Mother's Nama (First, Middle, Malden Surname) Be Russell Joseph Barger A. Virginia Weller 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zio Code) 21042–1339 19e. Informant's Name/Relationship (Type, Print) City, 12244 Pointer Hill Ct. Ellicott Wilma Barger/wife 20b. Place of Disposition (Nama of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cramation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hampstead, MD CARROLL CREMATION 1/4/2000 22. Name and Address of Facility 91 WILLIS STREET Myera MUERS FUNERAL HOME WESTMINSTER, MD, 21157 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in deeth) Examiner Examiner physician and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last certificata be exec heumatoi P.O. Box 68760, Physician/Medical 88 980 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yee 2 No 3 Probably 4 9 Onknown conpression tracture þ Division of Vital Records, 2 24b. Were autopsy findings available prior to complation of cause of death? 24a. Was an autopsy performed? Completed Bulmonary Aspiration Cervical Myelopathy
25. Was case referred to medicat
examiner? 2 No 1 Yes 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 Minpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 10 After this 27. Manner of Death 28a. Date of tnjury (Month, Day Year) funeral 28d. Describe how injury occurred 28h Time of Certification: 28c. Injury at Work? 5 Pending investigation Hospital or Attending eftar death. Director: Aft 1 Yes 2 No 2 Accident 6 Could not be determined 3 Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of tnjury - At home, farm, streat, factory, office building, etc. (Specify) 4 Homicide 24 hours e Funerei C 1 Certifying Phyeician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. 29e. Certifier Medical within 24 ho To the Fune completely fi (Check only one) To the 295. Signature and title of contilier 29c. License number 29d. Date signed (Month, Day, Year) 30-Name and agrees of pr neth (Item 23e) (Type, Print)

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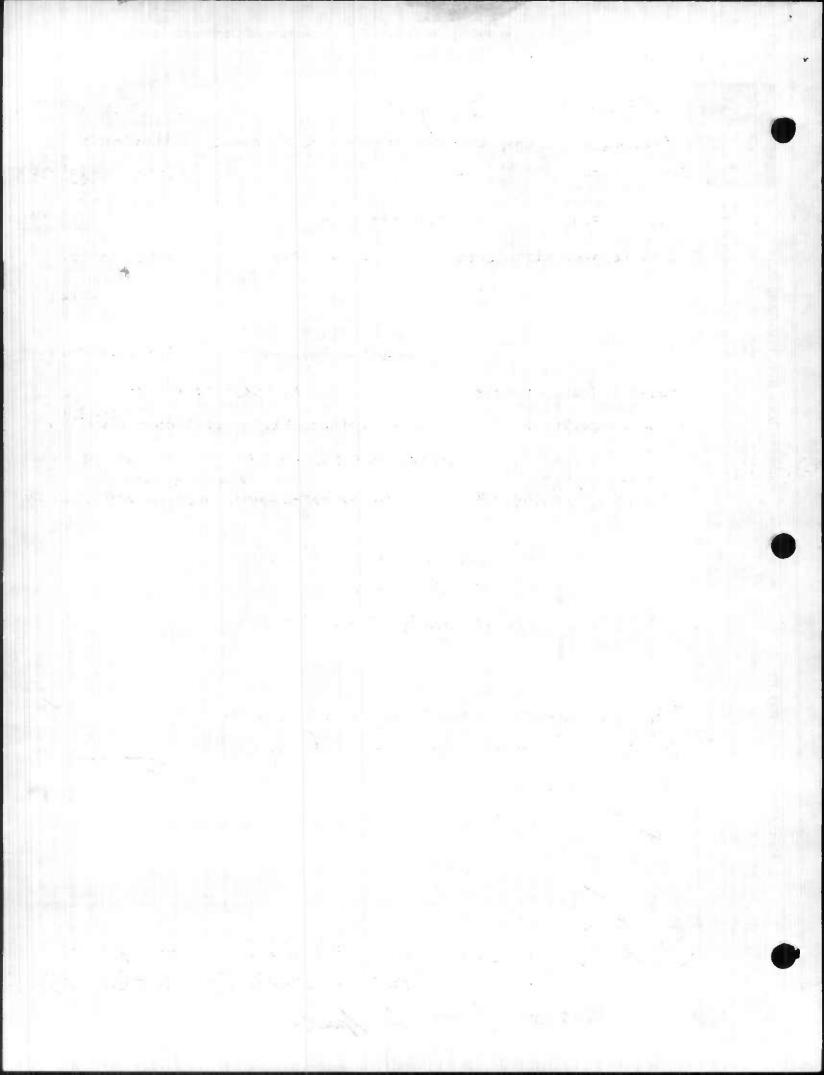
32. Registrar's Signeture

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State Registrar 31. Date filad (Menth, Day, Year)

JAN 07

2000



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Gordon Biggs, Sr. Month JAMUARY 0235 2000 4e. Fecility Neme (If not institution, give street end number, 4b. City, Town, or Location of Deeth 4c. County of Death Elkton Hospital Union If Under 24 Hrs. Hours Min. 6. Sex If Under 1 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 MM 2□ F 213-30-6696 67 Yrs. Usuel Residenca of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Ceci MD 1 Yes 2 No IKton 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 21921 USA 127 12. Was Decedent Ever in U.S. Armyd Forces? 1 'Yes 2 No If Yes, Give Yeer or Dates: 1953-1954 Was Decedent of Hispanic Origin? (Specify Yes or No-it Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Bleck, White, etc. 11. Marital Status 1 Never Married 2 M Married 1 Yes 2 No Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Buaineas/Industry Elementary/Secondery (0-12) Coilege (1-4or 5+) Inspector Health Department 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Evelyn Buckworth B. 10seph 19a. tnformant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rure! Route Number, City or Town, Stete, Zip Code) Jane Biggs/ MP 21921 Elkton maple 20a. Method ot Disposition 20b. Place of Disposition (Name of cametery, cremetory or other place) 20c. Location - City or Town, State 1 ■ Buriel 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Elkton, maryland 21921 main Street 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feilure. List only one cause on each line. Approximate Intervai Betw Immediate Ceuse (Finai disease or condition resulting in death) nary Artery Disense 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 WUnknown 1 Tyes 2 No 24b. Were autopsy findings available prior to completion of cause ot death? 24a. Was en autopsy performed?

Physician /Medical **Examiner**

signed by the atter

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this certificate

or Attending Physician: after death. Director: After this certifice funeral director,

Hospital
 24 hours
 Funeral

To the Hosp within 24 hou To the Fune completely fi

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Completed

Certification:

Medical

Division of Vital Records, P.O. Box 68760

Physician

/Medical

Examiner

10a. State

Director

Funeral

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Director

7 le marked other than "natural", or Itema 23a or 28a-f ehow treumatic event, the Moulcal Examiner must be notitled at

the Maryland

permit. Pages 1 and 2 should be filed within 72 hours effer death with the Department of Health and Mental hygiene. Important: If Item 27 le marked other than "not other treumatic—eny injury or other treumatic—eny.

Examiner physiclen and s the buriel-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In deeth) Last Physician/Medical 80 USB

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

26. Place of Death (Check only one)

1 ☐ Yes 2 ☐ No

2000

25. Waa case reterred to medical exeminer? 1 Yes 2 HO

1 Inpatient 2 ER/Outpatient 3 DOA

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred 1 Tyes 2 No

5 Pending Investigation Could not be 28e. Place of Injury - At home, tarm, street, tactory, offica building, etc. (Specify)

28t. Location (Street end Number or Rural Route Number, City or Town, State)

2 1 No

29a, Certifier (Check only one)

27. Manner of Death

1 Maturai

2 Accident 3 Suicide

4 | Homicide

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete and placa, and due to the cause(s) and manner as steted.

2 Medical Examiner: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, data and placa, and due to the cause(a) and manner stated.

29c. License number

and eddresa ot person who completed cause of death (Item 23a) (Type, Print)

JAYANTILALK PATELMD-123 SINGERLY HVE, ELKTOTY,

Registrar

12+1VA

32. Registrar's Signature

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Piease Type or Print in Black indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Tima of Death Month Year **Physician** Lee Winifred Brady 2000 Jan 1010 /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel 8. Date of Birth (Month, Day, Y Jan 19 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 Mary Land 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1 M 2 F 92 Yrs. 213-36-3848 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits Nerva 23a or 28a-f show ner must be notified at 1 Yes 2 No Directo Maryland Anne Arundel Annapolis 10e. Street and Number 10g. Citizen of What Country? 10f. Zin Code 956 Melvin Rd. (Colonial Manor Home) 21403 United States Funeral 12. Wes Decedent Ever In U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiens. Important: if Item 27 is marked other than "natural", or ite any injury or other traumetic event the Madesia. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0020 Specify: White 1 ☐ Yes 2 ☑ No Specify: by 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John F. Stevens Mary A. Gates 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jean Depew/ Daughter 149 Williams Dr. Annapolis, Md. 21401 20b. Place of Disposition (Name of cemetery, crematory or other placa) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremetion 3 Removal from State Cedar Bluff Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 01-05-00 Annapolis, Maryland of Funeral S 22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, Md. 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Ceuse (Final 2 WEEKS disease or condition resulting in death) Examiner Physician/Medical Examiner UNKNOW YEZIPHERAL the burial-transit The lew requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last Due to (or as a consequenca of) P.O. Box 68760. Due to (or as a consequenca of) use as Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably Unknown APDER CANCER Division of Vital Records. Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 28 No 1 Yes 2 No certificate or Attending Physician: filled in by the funeral director, Be 25. Was case referred to medical axaminar? 26. Place of Death (Check only one) Hospitat: 1 Appatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 🎾 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) Medical Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Describe how Injury occurred After 1 Natural 2 Accident 5 Pending Investigation within 24 hours after death. To the Funeral Director: Al 1 ☐ Yes 2 ☐ No NIA 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) \$ 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signetus, and title of certifier 2 01/01/00 D39037

State Registrar 31. Date filed (Month, Day, Year) JAN 0 4 2000

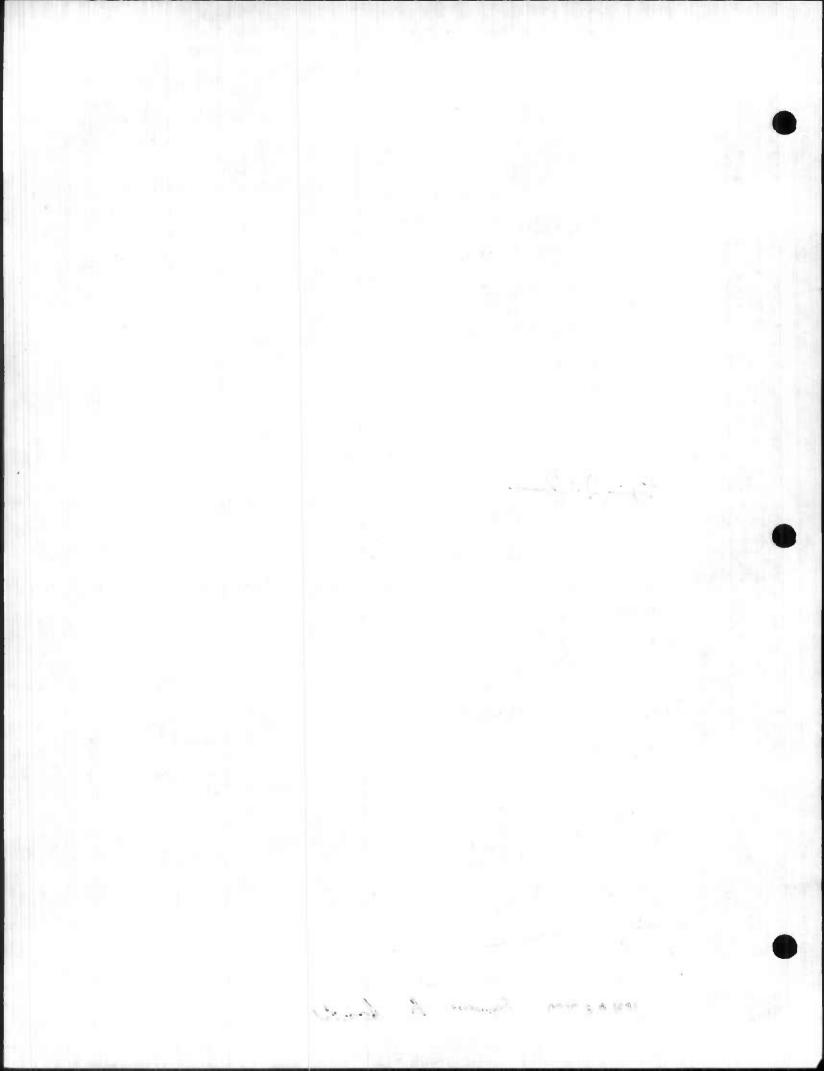
DOUGLAS

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ANNE ARUNDEL MEDICAL CENTER MITCHELL 32 Registrer's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ANNAPOUS, MD

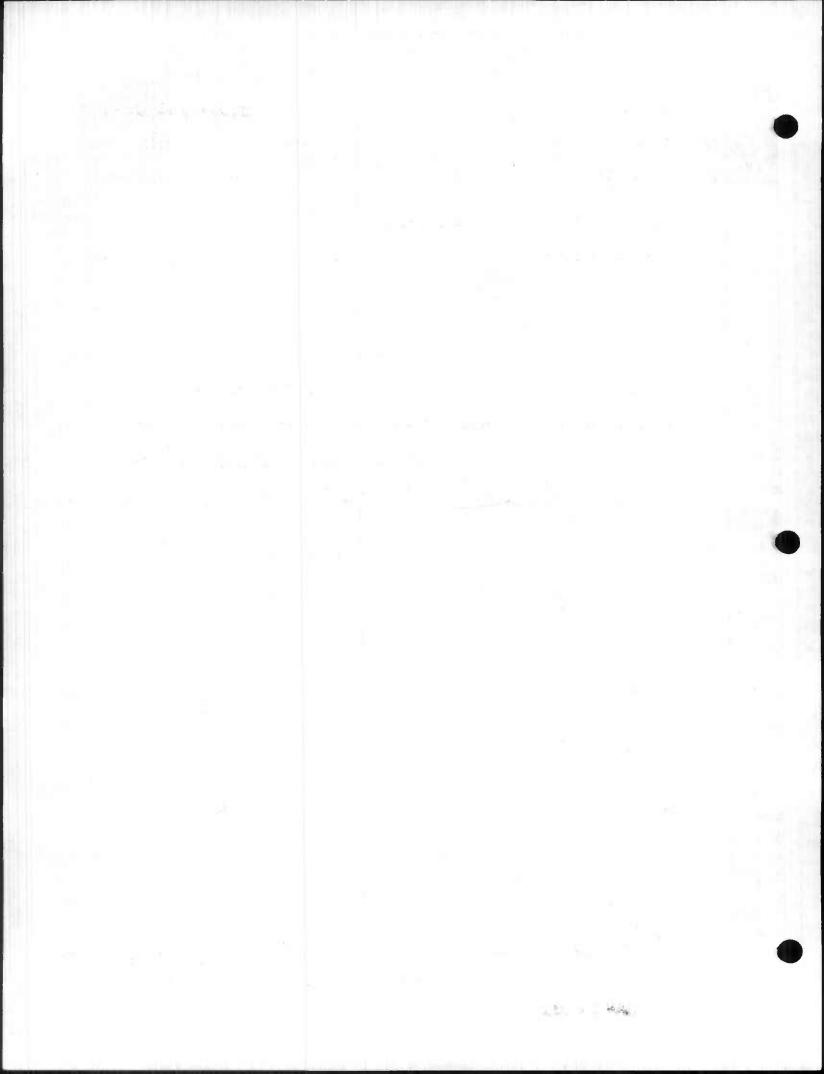


State of Maryland / Department of Health and Mental Hygien 0 02219

| | | | | Cei | rtificat | e of l | Death | | R | eg. No. | 0 (| - Los 1 0 |
|--|---|------------------------------------|---|------------------------|---------------|--------------------|----------------------------|------------|---|----------------------------|--------------|---|
| | 1. Decedent's Name (First, Middle, | Last) | | | | | | | 2. Date of Dea | | Vesr | 3. Time of Death |
| Physician /Medical | Eleanor F. Behl | ke | | | | | | | January | 9, 20 | OO | 8:00 A.M |
| /Medical Examiner | 4a Facility Name (If not institution, | ive street and nu | mber) | | | 4 | lb. City, To | wn, or Lo | cation of Death | _ | y of Death | |
| Examino, | Heritage Harbour | Health | & Rehab | ilitat | ion (| Ctr. | Anna | apol: | is | Anne | Arur | ndel |
| uneral | 5. Social Security Number 6 | Sex | 7. Age (In yrs. I | last birthday) | | 1 Year | If Under | | | | | place (State or Forei |
| rector | 216-34-8503 | 1□ M 21√ F | 89 | Yrs. | Months | Days | Hours | Min. | 8. Date of Birth (Month, Day Dec. 19, | 1910 | Cana | nda ada |
| E | 10e. State 10b. County | | 10c. City | y, Town or Lo | ocation | | | | | | | 10d. Inside City Limi |
| ada Po | Maryland Anne | Arundel | | A | apol: | | | | | | | 1 Tes 2 |
| outilise ecto | 10e. Street and Number | AI dildei | | AIIII | 10f. Zi | | | | 1 | 0g. Citizen of | What Cou | ntn/? |
| nerns 23e or 21e-f sho ner must be notified at uneral Director | 2550 West Course | Drive | | | 101.24 | 2140 |)1 | | | USA | | , |
| Der m | 11. Marital Status | 12. Was Dec | edent Ever in U, | S. 13. | Was Dece | dent of H | ispanic Ori | igin? (Spi | ecity Yes or No- Rican, etc.) | | ce - Ameri | can Indian, |
| by Fu | 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced | | 2 No ve | | 1□ Yes | ~~ | Specify: | | , , , , , | Specia | 4.0 | Vhite |
| disal | 15. Decedent's (Specify only highest (| | | 16a. Deced | kind of wo | rk done d | during mos | at of work | ing | 16b. Kind of E | Business/In | ndustry |
| t, the Medical | Elementary/Secondary (0-12) | College (| 1-4or 5+) | | bo NOT u | | | | | | Retai | 1 |
| | 17. Father's Name (First, Middle, La | st) | | | - ' | | | er's Name | e (First, Middle, i | Maiden Suma | me) | |
| To Be | Harry Wal | • | | | | | | Mabe | el Walke | r | | |
| 1 | 19a. Informant's Name/Relationship | (Type, Print) | | 19b. Mailir | ng Addres | (Street | and Numb | er or Run | al Route Number | . City or Town | , State, Zi | p Code) |
| the state of | Charlotte E. Kli | | mohter | | | | | | Annapol | | | |
| 60 | 20a. Method of Disposition | incii/ Do | 20b. P | tace of Dispo | sition (Na | me of | | TIVE | | 20c. Location | | |
| ury or | 1 Burial 2 □ Cremation 3 4 □ Donallon 5 □ Other (Spe | | | emetery, crer emont | Meml | Gar | dens | 1 | | | onvil | lle, MD |
| any in | 21. Signature of Funeral Banyle Lic | ensee | | Ge 29 | Name and orge | P. K | alas | Fune | eral Hom | e | r MT | 21037 |
| | 23a. Part1. Enter the disease, or co | mplications that | aused the death | | | | | | | | 1 , 111 | Approximate |
| sician | shock, or heart tailure. List on | ry one cause on a | each line. | | | | | | | | | Interval Between Onset and Death |
| edical | Immediate Cause (Final | | 0.400 | ntia | | | | | | | 1 | 1/10 |
| miner | disease or condition resulting in death) | a | emen Due to (or | uu | | | | | | | 1 | 413 |
| je le | | b. CO. | 1 CA 11A | T1110 | 11 | 001 | T | Ga | 1,10 | | 1 | months |
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| Exa | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events | 1 | 200000 | | 1.4.6 | 6 | · ni | 100 | lure | | | Man Tho |
| cal cal | Cause (Disease or Injury | c. T. | 71910 | as a conseq | (1) | UF | YIC | 10 | ay | - | - | Jo On III |
| ing physicis se as the bu | resulting in death) Last | | DDB 10 (04 | as a conseq | poerice or). | | | | , | | | |
| o by the attending the constant of the constan | | d | | | | | | | | | | |
| ysic | Part II. Other significant conditions | contributing to d | eath but not resu | ulting in the u | nderlying | ause giv | en in Part I | l. | 23b. Did to | becco use c | pritribute 1 | to the cause of dea |
| be detached by Physic | | | | | | | | | 1 U | es 2E No | 3 Pro | obably 4 Unkn |
| should | | | | | | 1 | | | 24a. Was a perfor | | 80 | Vere autopsy finding vailable prior to ompletion of cause I death? |
| page 2 | | | | | | | | | 1 Y | s 2PNo | | ☐ Yes 2☐ No |
| or, pa | OS Miss assessationed to madical | | | | | | | | | | | L 165 2L 140 |
| g m | 25. Was case referred to medical examiner? | Hospital: | | | | Oth | or _/ | | h (Check only or | | | |
| al di | 1 Yes 2 No | 28a. Date | | ER/Outpatier | | JA | 42 N | - | me 5 Resid | | | ify) |
| | 1 ☑Natural 5 ☐ Pending | (Mon | th, Day Year) | 28b. Time of Injury | | 28c. Injun Work | | | 28d. Describe h | ow milary occu | n red | |
| the Car | 2 Accident investigat 3 Suicide 6 Could not | he | | | М | | Yes 2□ | 140 | 00(1 10 | leant and the | har as A | ent Poudo Atria |
| ed in by the funer. | 4 Homicide | d 28e. Place | of Injury - At ho ing, etc. (Specify | ome, farm, str /) | reet, factor | y, office | | | 28f. Location (S City or Tow | | per of Hui | ral Route Number, |
| completely filled in by the funer Medical Certification | (Check only 2 Medical Ex | Physician: To the aminer: On the b | asis of examinat | wiedge, death | h occurred | at the tin | ne, date ar pinion, dea | nd place, | and due to the cred at the time, d | ause(s) and mate and place | nanner as | stated. to the cause(s) |
| ald De A | one) | and man | ner stated. | | 100 | | | | | 21.54 | 1 01 1 14 | O V |
| E 00 | 29b. Signature and sittle of certifier | _ | | | 29 | . Licens | e number | 20 | 2 | 9d. Date sign | eu (Month) | Day, rear) |
| | NITHO | MN. | | | | 1/4 | 119 | 10 | | 1-6 | 1-0 | 00 |
| | 30. Name and address of person wh | o completed caus | se of death (Item | 23a) (Type, | Print) | | | | | | | |
| | Nader Tavakoli. | M.D. | 1 Hos | nital | Drive | Ch | ever | lv N | Maryland | 20785 | | |
| State | 31. Date filed (Month, Day, Year) | | egistrar's Signa | ture 4 | 1 | - | 11 | - 3 9 1 | , | | | |

State of Maryland / Department of Health and Mental Hygiene

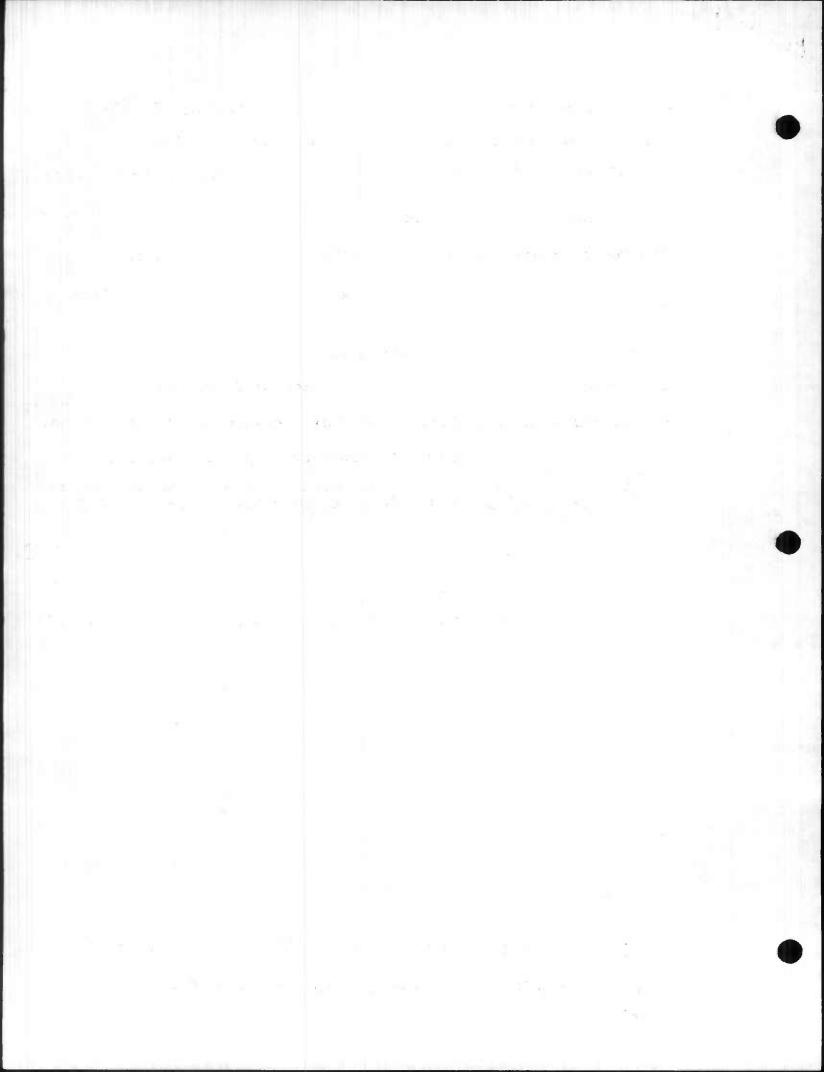
| | | | 1 December Name (First Middle | | iaryiaria / D | | ficate of | | R | eg. No. | 1 02 | 440 |
|---|---|----------------------|--|--|---|-----------------------|--|---|--|----------------------------------|---------------------------------|--|
| | Physic | ian | Decedent's Neme (First, Middle, | Last) | | | | | 2. Dete of Dee Month | th Dey | Yeer | 3. Time of Death |
| | /Medi | | Bernice Mary Bo | ur | | | | | Januar | | 2000 | 0803 |
| | Examir | | 4e. Fecility Neme (If not institution, | giva street and numbe | r) | | | 4b. City, Town, or | | 4c. Count | of Deeth | |
| | | | 629 Hances Poin | t Road | | | | North Ea | ct | Cecil | | |
| | Funerai | | | | ge (In yrs. last birth | ndev) | | if Undar 24 Hrs | | | | a (Steta or Foreign |
| | Director | | 179-22-4379 Usual Residence of Decedent | 1□M 2፟M F | | rs. N | Months Deys | | 8. Dete of Birth (Month, Dey vember 25 | , Year) 5,1928 | Country |) |
| arylend | ahow | 2 | 10a. Stete 10b. County | | 10c. City, Town | | ion | | | | 10d | . inside City Limits 1 ☐ Yas 2 ☒ No |
| 9 | 8 | Director | Maryland Cecil | | North I | | | | | | | |
| ē | 8 5 | 급 | 10e. Street and Number | | | | 10f. Zip Code | | 1 | 0g. Citizen of | Whal Country | 7 |
| E × | 234 | | 629 Hances Point | Road | | | 21901 | | | United | State | S |
| dee | E 5 | Funeral | 11. Marital Status | 12. Wes Deceden Armed Forces | t Ever in U,S. | 13. Wes | s Decedent of I | Hispenic Origin? (S | pecity Yes or No- | 14. Rac | e - American | Indien, |
| d 21215-0020 filed within 72 hours effer deeth with the Maryland | "natural", or frems 23a or 28a-f ahow botcal Examiner mant be notified at | by Fu | 1 ☐ Never Married 2 🕅 Marrie 3 ☐ Widowed 4 ☐ Divorced | | No | | Yes 2 No | | to rican, etc.) | Specif | ck, White, etc y: White | |
| O E | a is | | 15. Decedent's | Education | 16a (| Deceden | t's Usuei Occu | netion | | 16b. Kind of B | | |
| 21215-0020 d withlin 72 hours ef | | Completed | (Specify only highest Elementary/Secondery (0-12) | College (1-4o | 5+) | | | petion during most of wo d) | rking | TOO. KING OF B | 0311033/11003 | sti y |
| Ø . | Hygiene. ther than | S | 12 | | Но | omem | aker | 1 | | In her | | ome |
| Maryland | marked other | Be | 17. Fether's Neme (First, Middle, La | st) | | | | 18. Mother's Na | me (First, Middle, I | Maiden Sumer | ne) | |
| Aarylan 2 should be f | rke rice | Lo | F. Walter Kozio | ki | | | | M. Mary | Zdancewi | Lcz | | |
| and sho | DE S | 1 | 19e. informent's Name/Reletionship | (Type, Print) | 19b. | Meiting / | Address (Stree | end Number or R | ural Route Number | , City or Town | Stete, Zip Co | ode) |
| | 27 le | | Robert L. Bour, | Sr / Sno | use 629 |) На | nces Po | int Poad | , North I | Fact M | nev1 and | 1 21001 |
| Baltimore, | item 27 i | | 20a. Method of Disposition | DI. / SPO | 20b. Place of I | Dispositio | on (Neme of | | | 20c. Location | | |
| 0 8 | 0 = 0 | | 1 ☐ Burlei 2 X Cremation 3 | | cemetery | , cremete | ory or othar ple | ce) | T | 7 . (7) | | |
| E P | lant land | | 4 Donetion 5 Other (Spe | oify) | R.A. Fe | rris | s Compa | ny, Inc. | nuary 14,2000 I | Pennsy1 | vania | |
| Baltimor | Department of important: If I any injury or once. | | 21. Signeture of Funeral Service U | ense | 7 | _ | eme end Addre | | | | | |
| 10 8 2 | 2 5 8 8 | | 11/nf. A. | and | | | | eral Hom | | | | and 21901 |
| Ex | Medical aminer | Examiner | Immediate Causa (Final disease or condition resulting in death) Sequentially list conditions, | . My o | Due to (or es e co | onsequer onsequer | the capital control of the capital cap | Arrest | | | | |
| BOX 68 760, sath certificate be executed | ettending physician and for use as the buriel-transit | Physician/Medical Ex | Sequentially list conditions, if any, leeding to Immadiate cause. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in death) Last | c | Due to (or as a co | nsequen | nce of): | | | | | |
| des | ed fo | SIC | Pert II. Other significant conditions | contributing to death | but not rasulting In | lhe unde | rlying causa gi | van in Part I. | 23b. Did to | bacco usa co | ntribute to th | e causs of death? |
| P.O. | ned by t | by Phy | Subarechnoi | d Hen | on hege | • | 1990 | | y Ov | 88 2 No | 3 Probat | oly 4 Unknown |
| Hecords, P.O. Box The law requires thet the death ce | has been signed by the ge 2 should be detached | Completed to | Serve I | Forder | | | | | 24e. Wes e perform | n eutopsy ned? | evaile | autopsy findings bbte prior to letion of cause ath? |
| ع ع | ate ha | 5 | | | | | | | 1 🗆 Ye | s 2 No | 1 🗆 Y | es 2 No |
| | | 0 | 25. Wes case referred to medical | | | | | 26 Place of Do | eth (Check only on | | | |
| OT VITA | | CO | examiner? ≥ Yes 2 No | Hospitet: | ion: 2 - 50/0 | natio-4 | all post Ot | har | 1 | | (0 | |
| O M | this praid | . To | 27. Manner of Deeth | 1 U inpat | | | 3LI DON | 4 LI Nuising r | 10me Seside | | | |
| E B | stor: After y the funer | atlon | Naturel 5 Pending Investige | | ey Year) Inj | ury | 28c. Inju Wo M 1 | rk? Yes 2 □ No | 200. Describe in | ow injury occur | 160 | |
| DIVISION fel or Attending | within 2- hours after deem. To the Funeral Director: A completely filled in by the fu | Certification: | 3 Suicide 6 Could no determine | d 28a. Placa of ir | ijury - At homa, ferr tc. <i>(Specify)</i> | n, street, | , factory, office | | 28f. Location (St City or Town | | per or Rural R | louta Num <i>ber,</i> |
| HOSP | Detely fil | edical | 29a. Certifier (Check only one) 1 Certifying Medical Ex | Phyelcian: To the best aminar: On the basis end menner s | of examinetion end/ | deeth oc or Invest | curred et the ti tigation, in my o | me, dete end piece opinion, deeth occu | a, end due to the coursed at the time, d | euse(s) end ma ate and piece, | enner es state and due to th | ed. e cause(s) |
| To the | Toth | X | 29b. Signeture and title of certifier | 00 | 20 | | 29c. Licens | se number | 2 | 9d. Deta signe | d (Month, Da | y, Year) |
| , , | | | M1.00 | 42 1 | 1 / 41 | | Do | -2007 | - | | 13 | 2 |
| | | | - rull | 1 Jul | () 104) | | DS | 900 | | 120000 | 213, | 2000 |
| 1 | 10 | | 30. Neme end eddress of person wh | o completed cause of | - | • | nt) (| unio- | tospital | zne | Benel | À |
| | | | Michael J. | riarulli | Jr. M! |) | | 500 B | ow Str | eet | CINTU | x, MD. |
| | Sta | ite | 31. Dete filed (Month, Dey, Year) | 32. Regist | rer's Signatura | 4 | 1 | , | | | | |



| , | | - | - 40 | |
|--|-----|-----|------|---|
| State of Maryland / Department of Health and Mental Hygiene | 5 6 |) (|) | 3 |
| State of Manuand / Department of Health and Montal Hygionia II | 1 1 | 1 1 | 1 | , |
| State of Maryland / Department of Health and Mental Hydrene | 16 | - 6 | . 6 | |
| | 2 0 | | | |
| 0 110 1 1 0 11 | | | | |

| | | | | | Ce | rtificate | of | Death | | R | eg. No. | | | |
|--|----------------|--|--|-------------------|------------|--|--------|----------------|------------|--|----------------|---------------|--|---------------|
| | | 1. Decedent's Neme (First, Middle, L | ast) | | | | | | | 2. Dete of Deet | th | | 3. Time of | Deeth |
| Physic | | BERTHA ELMA | BARCLAY | , | | | | | | Januar | v 13 | 2000 | 6:00 |) am |
| /Med Exami | | 4e. Fecility Neme (If not institution, g | | • | | | | 4b. City, To | wn, or Lo | cation of Deeth | 4 | ty of Deeth | 0.00 | Calli |
| LAdilli | 1161 | 1155 Cecilto | n-Warwick | Rđ. | | | | War | wick | - | Ceci | | | |
| Francis | _ | | | e (In yrs. last l | birthday) | If Under 1 | Yeer | | | | | _ | ece (State o | r Foreign |
| Funerai Director | | 221-10-5775 | 1□ M 2 X F | 87 | Yrs. | Months | Deys | Hours | Min, | 8. Dete of Birth (Month, Day, August | | Count | TEN | |
| D | | Usual Residence of Decedent | | | - | | | | | August | 12 1 | 712 | 1 151 | 114 |
| ylan | | 10a. Stete 10b. County | | 10c. City, To | wn or Lo | ocation | | | | | | 10 | d. Inside Ci | ty Limits |
| the Marylar 28a-f ahow | Į p | MD Ceci | 1 | Warw | ick | | | | | | | | 1 🗆 Yes | 2 X No |
| r 28 | Director | 10e. Street end Number | | 1 | | 10f. Zip C | ode | | | 1 | 0g. Citizen of | Whet Count | iry? | |
| 3a o | 0 | 1155 Cecilton | -Warwick | Rđ. | | 21 | 19 | 12 | | | U.S. | λ | | |
| Jeath The 2 | Funeral | 11, Maritel Status | 12. Wes Decedent | | 13. | | | | igin? (Spe | ecify Yes or No- | | ce - America | an Indien. | |
| fer fer | F | 1 Never Merried 2 Married | Armed Forces? | No | | If Yes, specify | / Cub | oan, Mexicer | n, Puerto | Rican, etc.) | | eck, White, e | etc. | |
| d within 72 hours after death with the Maryland jiene. I than "natural", or Itema 23a or 28a-f ahow the Marical Examiner must be notified at | by | 3XWidowed 4 ☐ Divorced | If Yes, Give Yeer or Detes: | | | 1 ☐ Yes 21 | No. | Specify: | | | Speci | ty: Wh | ite | |
| 72 hours | | 15. Decedent's I | Education | 16 | e. Dece | dent's Usuei (| Occu | petion | | | 16b. Kind of E | Business/Ind | ustry | |
| | Completed | (Specify only highest g | rede completed) | | (Give | kind of work DO NOT use | done | during mos | t of work | ing | | | , | |
| filed within Hygiene. ther than | EO | Elementery/Secondary (0-12) | College (1-4or 5 |)+) | Hon | nemake | r | | | | Home | | | |
| | | 17. Fether's Name (First, Middle, Las | it) | | | | | 18. Mothe | er's Neme | (First, Middle, M | | me) | | |
| 2 should be filed and Mental Hygi a marked other summitic event, | o Be | Ike Sanders | | | | | | Tda | Li | nda Wi | leon | , | | |
| d 2 should th and Men 7 Is marks traumatic | 1º | 19e. Informent's Neme/Reletionship | (Type Print) | 16 | Oh Mailir | na Addrose // | Stron | | | al Route Number | | Ctoto Zin | Codol = | |
| 2 4 4 4 | | Linda B. Fenim | | | | | | | | | | | 4 | 191 |
| Tan Heal | | 20e. Method of Disposition | ore (da | | | osition (Name | | CIIto | n-w | arwick | 20c. Location | | | D. |
| 0 = 0 = 0 | | 1 ☐ Buriel 2 Cremetion 3 | Removal from State | ceme | tery, crer | matory or other | er ple | | | | | | | |
| mit. Pages 1 as pertment of Hea portant: If Item; y injury or other ce. | 1 | 4 ☐ Donation 5 ☐ Other (Spec | ify) | Capi | tol | Crem | nat | tory | 1, | /14/00 | Dove | r, DE | | |
| permit. Pages Depertment of Important: If Ite any injury or of | 1 | 21. Signature of Funeral Service Liq | Misee 0 | | | 2. Name end | | | | ome of | Chanl | han C | ahaa. | 1- |
| 20539 | | The | 244 | 00510 | | | | | | t. Gale | | | | en |
| | Г | 23e. Parti. Entir IIII disease, or cer | nplicetions that caused | the deeth. De | | ter the mode | of dyl | ing, such es | cerdiac o | or respiretory error | est, | MD. Z | 1635 Approximete | В |
| Physician | | shock, or buart failure. List onl | y one ceuse on eech in | 10. | | | | | | | | | Intervel Bet Onset end I | veen Jeeth |
| /Medical | | Immediete Ceuse (Finel | CV | A | | | | | | | | 1 | IMA | 15 |
| Examiner | п | diseese or condition resulting in death) | е | | | | | | | | | | 11-11 | 10 |
| | ē | | ASC | Due to (or as | e consec | quenca or): | | | | | | | 199 | 7- |
| icate be executed physicien and s the burial-transit | Examiner | Constant to the first one division | b | Due to (or es | | ************************************** | | | | | | - | /// | ٦ |
| ertificate be executed ling physicien and e as the burial-transit | Exa | Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying | Ma | 11. | - | | 1 | em | 0 0 7 | 4. | | | 100 | |
| ficate be ex physicien as the burial | cal | Cause (Disease or Injury thet Initieted events | c | | | - | C) | C110 | 2111 | 100 | | | /// | > |
| g phy as th | Medical | resulting in deeth) Lest | | Due to (or es a | conseq | quence or); | | | | | | | | |
| 0 0 0 | | | d | | | | | | | | | | | |
|) to the | Physician | | | | | | | | | | | | | |
| . 0 00 | ysi | Pert II. Other eignificant conditions | contributing to death be | ut not resulting | In the u | inderlying ceu | se gi | iven in Part I | l | 23b. Did to | bacco uee c | ontribute to | the ceuse o | of death? |
| that the ed by the detache | | | | | | | | | | 1 🗆 Y | es 2 No | 3 Prob | ably 4 | Unknow |
| 7 8 5 6 | by | | | | | | | | | | | T | | |
| v requires been sign should be | Completed | | | | | | | | | 24e. Wes e perforr | | eve | re autopsy f iteble prior to npletion of c | 0 |
| The law ste has b | pldu | | | | | | | | | | | | leeth? | 5036 |
| The la ate has page | 50 | | | | | | | | | 1 □ Ye | s 28 No | 1 | Yes 2 | No |
| | Be (| 25. Wes cese referred to medical exeminer? | | | | | | 26. Place | of Deeth | Check only on | e) | | | |
| | 10 T | 1 ☐ Yes 2 X No | Hospitel: 1 ☐ Inpatie | nt 2 ER/C | Outpetler | nt 3 DOA | Ott | her: 4 Nu | irsing Ho | me 5.8 Reside | ence 6 □Ot | her (Specify |) | |
| ding Phys h. After this funeral di | | 27. Menner of Deeth | 28e. Dete of Injur (Month, Day | y 28b | . Time of | 1 280 | . Inju | ry et | | 28d. Describe ho | w Injury occu | irred | | |
| f or Attending after death. Director: After | Certification: | 1 Accident 5 ☐ Pending 2 ☐ Accident Investigation | | 7001) | injury | M | | Yes 2 | No | | | | | |
| i or Attending after death. Director: After de in by the fu | Ific | 3 ☐ Suicide 6 ☐ Could not determined | 286. Pieca of Inju | ry - At home, | ferm, str | reet, factory, o | office | | | 28f. Location (St | reet and Num | ber or Aurai | Route Num | ber, |
| d afte | ert | 4 Homicide | building, etc | :. (Specity) | | | | | | City or Town | i, State) | | | |
| To the Hospital or Attenwithin 24 hours after deat To the Funeral Director: completely filled in by the | | 29e. Certifier 12 Certifying P | hysician: To the best of | of my knowledg | ne. death | h occurred et | the ti | ime, dete en | d plece. | and due to the ce | euse(s) and m | nenner as st | eted. | |
| Ho Fu | edical | (Check only 2 Medical Exa | miner: On the basis of end menner sta | examination e | nd/or In | vestigetion, In | my | opinion, dee | th occurr | ed et the time, da | ate and pleca | , and due to | the ceuse(s |) |
| of this | Me | 29b. Signeture end title of certifier | | | | 29c. l | icens | se number | | 2 | 9d. Date sign | ed (Month, L | Dey, Year) | |
| F S F Ö | | Pat. | Qua. | o m | 7 ~ | - D | 7 | 281. | 3 | | | 3-0 | | |
| 0 | | · I avucia | The the | 0 /// | 1 | | | 201 | | | /-/ | 0 6 | 10 | |
| 2 | | 30. Name and eddress of person who | completed cause of de | | | | | | | | | | | |
| | | Patricia Gre | ve MD 25 | 1 S. | Boh | emia | Av | re. C | eci | Lton MI | 2191 | 13 | | |
| Sta | | 31. Dete filed (Month, Dey, Year) | 32. Registre | er's Signeture | / | 1 | | | | | | | | |
| Regist | ar | JAN 1 4 2000 | Lague | - / | . / | spork | 2 | | | | | | | |

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Deta of Death 3. Time of Death Month Nona Thomas Creighton January 17, 2000 6:10 AM 4e. Fecility Nema (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death 313 Shepherd Avenue Cambridge Dorchester Months Days Hours Min. 8. Data of Birth (Month, Day, Year) July 30, 1933 5. Sociei Security Number 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foreign Country) 1 M 2 F 220-26-0927 Yrs. 66 July Maryland Usuai Residence of Dacadant 10e. Stata 10b. County 10c. City, Town or Location 10d. fnside City Limits Maryland Dorchester Cambridge 1 XX as 2 □ No 10e. Straat and Number 10f. Zip Coda 10g. Citizen of What Country? 313 Shepherd Avenue 21613 US 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puarto Rican, atc.) Race - American Indien, Bieck, White, etc. 1 Nevar Marriad 2 ☐ Married If Yes, Giva Yaar or Datas: 1 ☐ Yas 2 📉 No Specify: Specify: White 3 ₩idowed 4 Divorced 15. Decedant's Education (Specify only highast grada complated) 16a. Decedent's Usuel Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry Elemantary/Secondery (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maldan Surnama) Lester Q. Thomas Netha Moore 19a. informant's Name/Raiationship (Type, Pnint) 19b. Mailing Address (Street end Number or Rural Routa Number, City or Town, Steta, Zip Code) Patricia Simmons Niece 1752 Hoopersville Road Hoopersville, MD 21634 20a. Mathod of Disposition 20b. Piace of Disposition (Name of cematary, cramatory or other place) 20c. Location - City or Town, Stata Data MaBurlal 2 Cramation 3 Ramoval from Stata Dorchester Memorial Park 1/19/2000 Cambridge, Maryland 4 Donation 5 Other (Specify) 21. Signatura of Funaral Servica Licensaa 22. Name and Addrass of Facility Thomas Funeral Home, P.A. 700 Locust Street Cambridge, Maryland 21613
23a. Part 1. Enter the disease, or complications that ceused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest,
Approximate Interval Between Onset and Deeth Immediata Causa (Finel Liver Wetastages 20 mo disaase or condition resulting in death) 16 YR alle Car Sequantially list conditions, if any, leading to immadiate ceuse. Enter Undarlying Causa (Disaasa or Injury that initieted avants resulting in daath) Last Due to (or es a consequence ot): Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceusa given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 Yes 20 No 3 Probably 4 Unknown 24b. Ware autopsy findings eveilabla prior to completion of causa of daath? 24e. Wes an autopsy parformad? 1 ☐ Yas 2 ☐ No 1 ☐ Yas 2 ☐ No 26. Piaca of Daath (Check only one) Other: 4 Nursing Home 5 Phasidance 8 Othar (Specify) 1 ☐ inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manper of Deeth 28e. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Panding 1 ☐ Yas 2 ☐ No invastigation

Physiclan /Medical Examiner ician and burial-transit

physician s the burial

signed by I

peen

certificate

funeral

completely

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifice

8 ō

Physician

/Medical

Examiner

Director

Funeral

þ

Completed

Funeral

Director

of 2 should be tilled within 72 hours after death with the Marylar th and Merket 19gjene.
7 is merked other than "natural", or items \$3s or 28s-f show traumstic event, the Medical Examiner mant be positived at

permit. Pages 1 and 2 should be that Department of Health and Mental Hy Important: If Nam 27 is marked oths any injury or other traumetic event.

Maryland 21215-0020

Baltimore,

Box 68760

P.O.

Records,

Division of Vital

Examiner

Physician/Medical by Completed Certification: To

edical

25. Was case rafarred to madicei axaminar? 1 Yas 2 No

> 1 M Naturel 2 Accidant

3 Suicide 4 | Homicide

29a, Certifiar

6 Could not be datarmined

28a. Place of Injury - At home, farm, street, factory, office building, atc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Cartifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner es stated.

2 Medicat Examiner: On the besis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and menner stated. 29b. Signatura and title of cep ausel

29c. Licansa number

29d. Data signed (Month, Day, Year)

30. Nema and addrass of person who complated ceusa of death (Item 23a) (Type, Print)

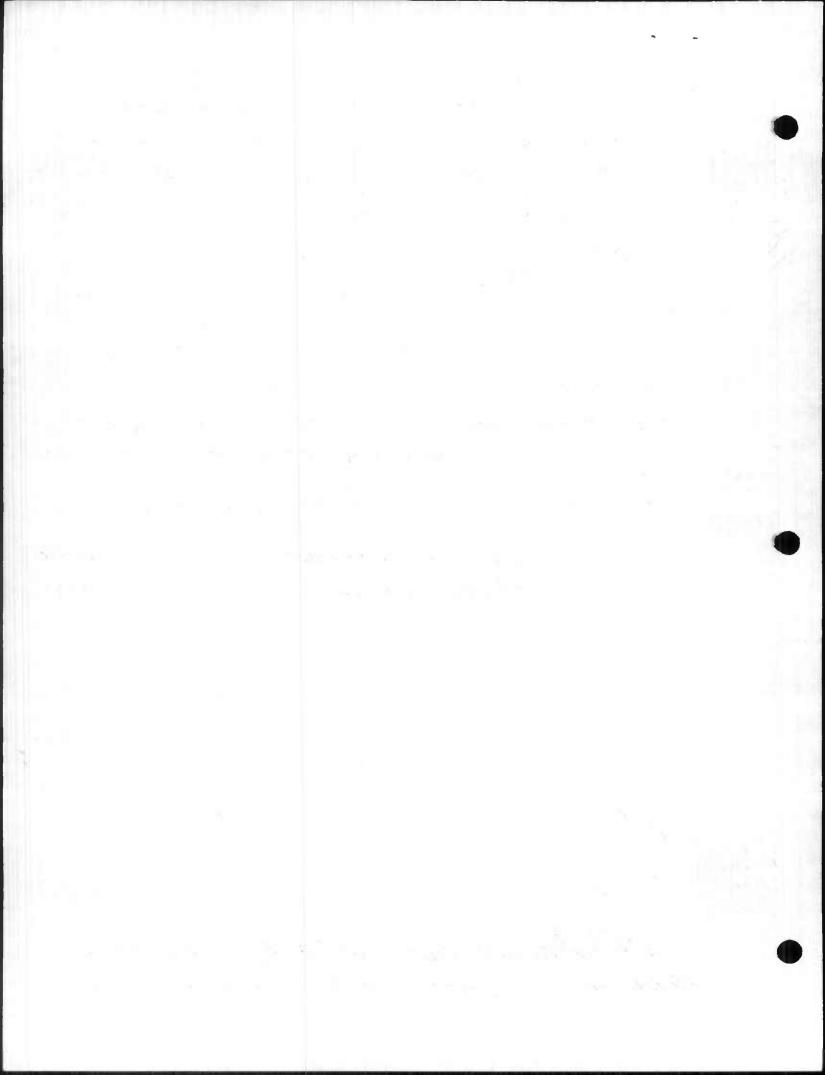
2 AURERA 37 PAIG CALDWELL

31. Data filed (Month, Dey, Yaer) JAN 1 8 2000

32. Ragistrar's Signature Denew

Cambeide Mid

State Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** Herman Brooks Coulbourn 0553 12, 2000 Jan. /Medical 4a. Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Dorchester 5941 Cokesbury Road Cokesbury if Under 1 Year if Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 7. Aga (In yrs. last birthday). 5. Social Sacurity Number Birthpiaca (Stata or Foreign Country)
 MC . **Funeral** 1 XM 2 F 218-14-4054 Director Dec. 21, 1922 Usual Rasidance of Dacedant 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No Director Seaford, DE MD Dorchester 10e. Street and Number 10f. Zip Coda 10g. Citizen of Whet Country? na 23e or 3 must be n United States 19973 5941 Cokesbury Road terns 23e Funeral 12. Was Dacedant Ever in U.S. Armed Forcas? 1 M Yas 2 □ No If Yas, Giva Yaer or Datas: 1 4 3 – 4 5 13. Was Dacedant of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian, Black, Whita, etc. Hygians. ther than "natural", or Item int, the Medical Examiner. 1 Navar Marriad 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☐ No Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decadant's Education (Specify only highast grada completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry filled within Elementery/Secondary (0-12) College (1-4or 5+) Agriculture/Poultry Farmer/Poultryman 17. Fathar's Nama (First, Middle, Last) 18. Mothar'a Nema (First, Middle, Maiden Sumame) Pages 1 and 2 should be Ills ment of Health and Mental Hi lant: If Item 27 is marked oth lury or other traumstic even Be Viola Wheatley Charles Coulbourn 19b. Malling Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Informant's Name/Ralationship (Type, Print) 5941 Cokesbury Rd., Seaford, DE 19973 Ida Lee Coulbourn/Spouse 20b. Place of Disposition (Name of cemetery, cremetory or other place) Data 20c. Location - City or Town, Stata Department of Important: If Ib any Injury or o 1 ☑ Buriai 2 ☐ Cramation 3 ☐ Ramoval from State Cokesbury, Maryland 1/14 Cokesbury Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Addrass of Facility
Framptom-Hawkins-Eskow Funeral Home, PA 21. Signatura of Funarai Service Licensaa 4 skin PO Box 43, Federalsburg, MD 21632 23a. Part1. Enter the disease, or complications that caused the deeth. Do not anter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete Intarval Batween Onset and Death **Physician** /Medical tmmediata Causa (Final Lung CANCEY 1 year disaasa or condition rasulting in daath) Examiner Dua to (or es e consequence of): Examiner ician and burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that in lead whether the conditions of the condi Dua to (or as a consequence of): physician the buria Box 68760 Physician/Medicai that initiated avants resulting in deeth) Last Dua to (or as a consequence of) P.O. Part ti. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Dtd tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Wara autopsy findings available prior to complation of causa of death? 24a. Was en eutopsy performed? Completed page 2 s 1 Yas 2 No 1 ☐ Yas 2 ☐ No Division of Vital or Attending Physician: director 25. Was casa rafarred to medical Be 26. Placa of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 ☐ Nursing Homa 5 ☐ Rasidanca 6 ☐ Othar (Specify) 1 Yes 2 No Certification: To this funeral 28a. Data of injury (Month, Day Year) 27. Mannar of Death 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred After 5 Panding Invastigation 1 Netural after death. 1 ☐ Yas 2 ☐ No 2 Accidant 6 Could not be datermined 3 Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Place of Injury - At homa, farm, straat, factory, offica building, atc. (Specify) filled in by 4 ☐ Homicida 24 hours a Funeral C Hospital 29a, Cartifian Medical 🕊 Cartifying Physician: To tha best of my knowledge, deeth occurred et the time, dete and plece, and dua to the causa(s) end manner as stated within 24 hor To the Fune completely fi (Check only one) 2 Madical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signatura and titla of cartifian 29c. Licansa number 29d. Data signed (Month, Day, Year)

State Registrar 30. Name end eddrass of person who completed causa of death (Itam 23a) (Type, Print)

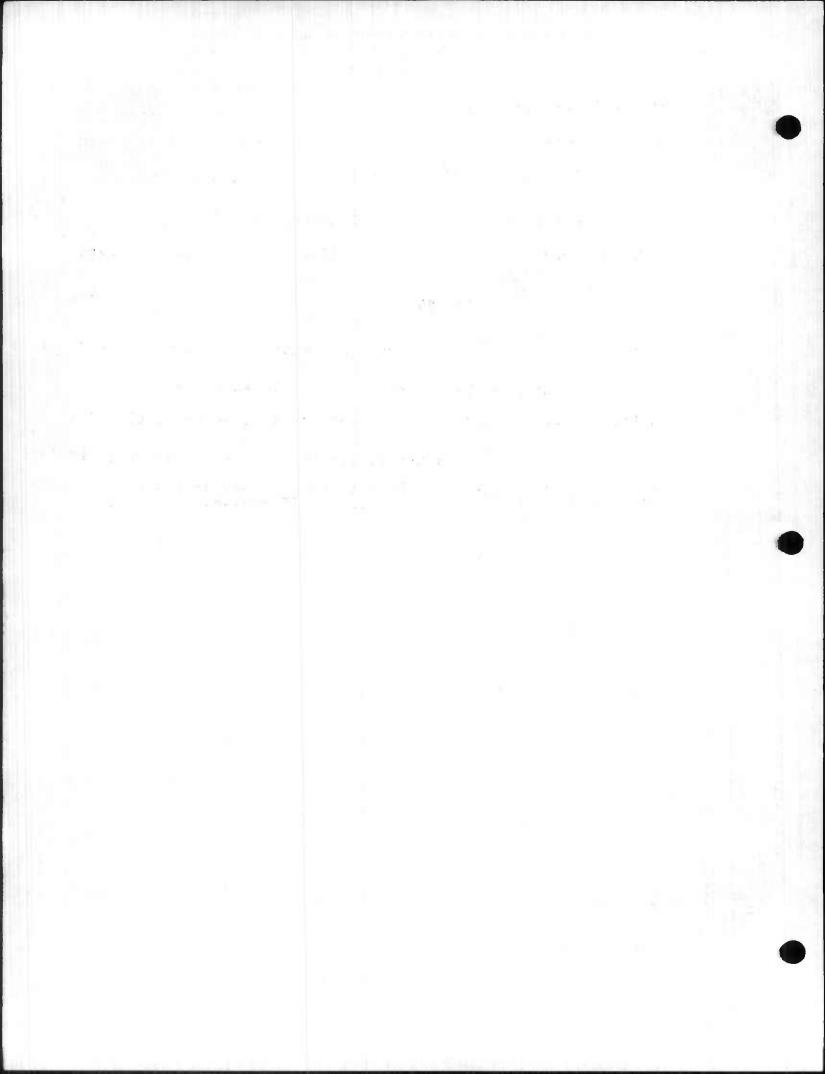
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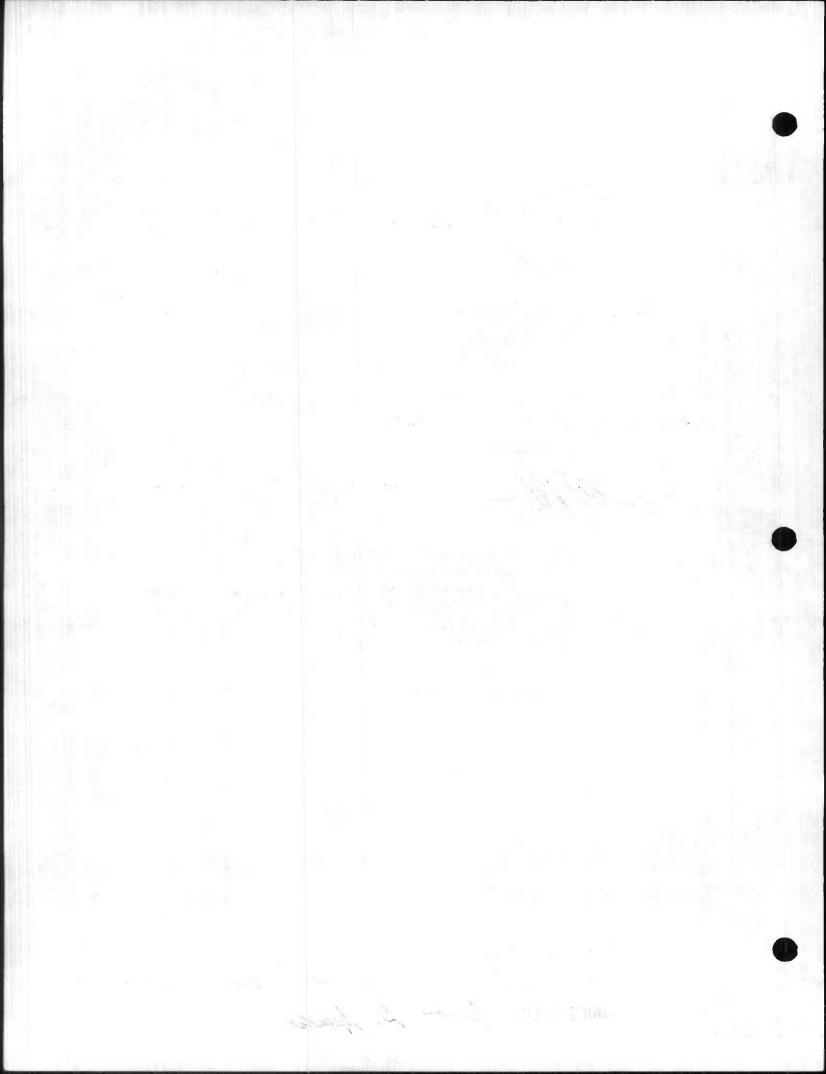
402 East 4th Street, Laurel, DE 19956

1/12/00



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| niner | | | | | | | | | | | y of Death | |
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| Funeral | 11. Marital Stetus | 7 1 1 1 0 | 12. Was De | ecedent Ever | in U,S. 13. | Was Decedent of | Hispanic Ori | gin? (Spe | cify Yes or No | | ce - Americ | |
| ģ | 1 Never Married 2 3 3 Widowed 4 □ Div | | | Forces? s 2 XNo Give Dates: | | If Yes, specify Cut 1 ☐ Yes 2 ☒ No | | | Rican, etc.) | | y: White, | |
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| 9 Be | 17. Father's Name (First, M Frank Wolff | noure, Last, | , | | | | | | Barnes | , Maiden Sumai | m e) | |
| 2 | 19a. Informant's Name/Ret | tetionehin / | Type Drines | | 10h 84-16 | ing Address (Stree | | | | | State 75 | Code) |
| | Susan Harriso | | | | | Burkitts | | | | | | |
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| | shock, or heart failure | e. List only | one cause on | each line | | | | | | | | |
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Transy marie Katherine



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death Month **Physician** 12, 2000 1550 January MARLIN SADDLER CLEVENGER /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Talbot The Memorial Hospital at Easton Easton If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) 8. Data of Birth (Month, Day, Year) **Funeral** Days Months Hours 1₩ 2□ F 218-16-8035 74 Director Maryland May 12,1925 Usual Residence of Decedent 10a. Stata 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at Queen Anne's Grasonville 1 ☐ Yes 2 ☑ No Director Md. 10a. Street and Number 10f. Zio Code 10g. Citizen of What Country? 8 213 Clevenger Road 21638 U.S.A. Нета 23а 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 12. Was Decedent Ever in U,S. Armed Forces? ₹☐Xas 2 ☐ No ff Yes, Give Year or Dates: WW 1 1 14. Race - Amarican Indian, 11. Marital Status Black, Whita, atc. 1 Never Merried 2 Marned "natural", or 1 Yes 2 No Specify: Specify: White by 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Law enforcement Elementary/Secondary (0-12) College (1-4or 5+) Maryland State Police Maryland State Polic 17. Father's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumame) Be E. Frank Clevenger Leola Saddler 19a. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 213 Clevenger Road Department of Health of Important: If New 27 is any injury or other tre pace. Betty M. Clevenger (Wife) Grasonville, Md. 21638

Jan. 15, 2000

City or Town, Stata 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Woodlawn Memorial Park Easton, Md. 22. Name and Address of Facility 21. Signatura of Funarat Service Life Fellows, Helfenbein & Newnam Funeral Home 408 S. Liberty St., Centreville, Md.

Approximate Interval Between Onset and Deeth **Physician** /Medical Immediate Causa (Final ZWKS Pneumonia disaasa or condition rasulting in daath) Examiner Due to (or as a consequence of): Examiner sician and burial-transit Sequentially list conditions, if any, leeding to immediate causa. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical eut. Due to (or as a consequence of): Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 1 Yea 2 No 3 Probably 4 Unknown CVA signed b þ 24b. Ware autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy DW CAD 1 Yas 2 DA 1 ∏ Yas 2 ∏ No. 25. Was casa referred to medical Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No Certification: To 1 Department 2 ER/Outpatient 3 DOA this 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 28a. Data of Injury (Month, Day Year) After 1 DNatural 5 Pending 1 Yes 2 No invastigation hours after death 2 Accident 6 Could not be 3 □ Suicide within 24 hours after de To the Funeral Directo completely filled in by th 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifler 29d. Data signed (Month, Day, Year) 29b. Signature and titla of certifier 29c. License number 00 30. Nama and address of person who completed cause of death (Item 23a) (Type, Print) Peter L. Whitesell, M.D., 503 Idlewild Ave., Easton, Md. 21601 32. Registrar's Signatura 31. Date filed (Month, Day, Year) JAN 1 4 2000 State Registrar

DHMH 16 Rev 6/95

that the death certificate be executed

Box 68760

P.O.

Records.

of Vital

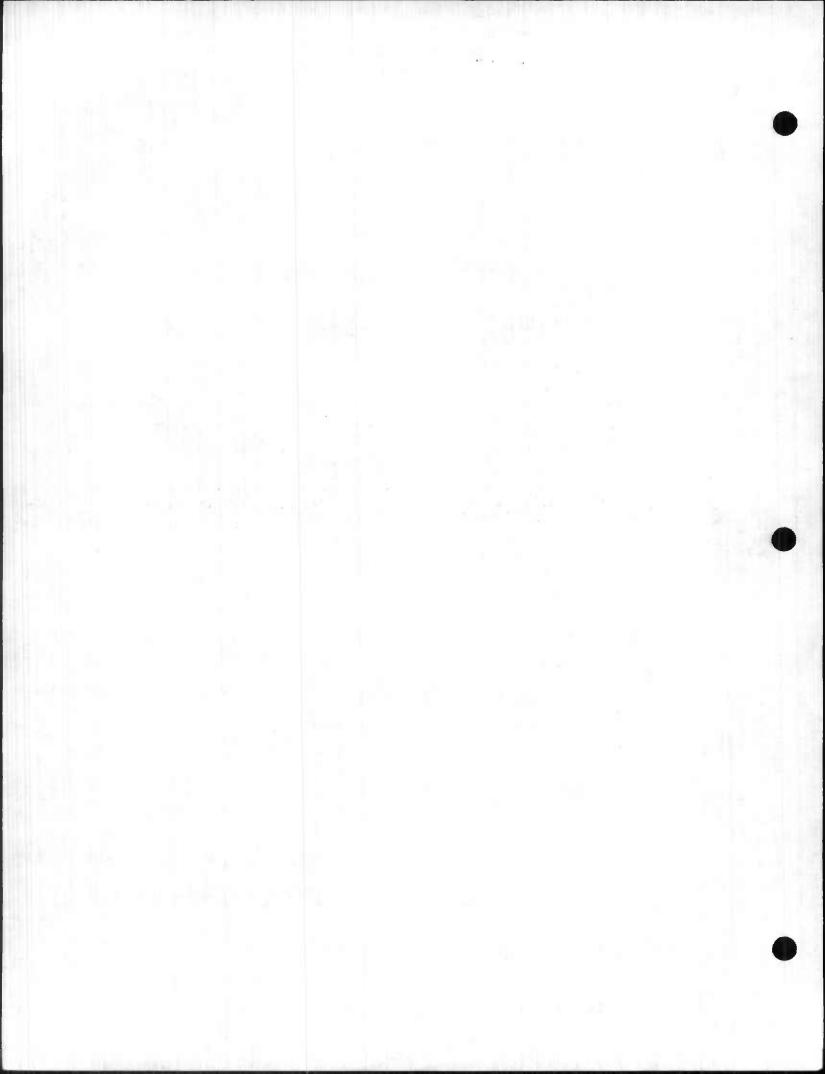
Division

or Attending Physician:

Hospital

To the

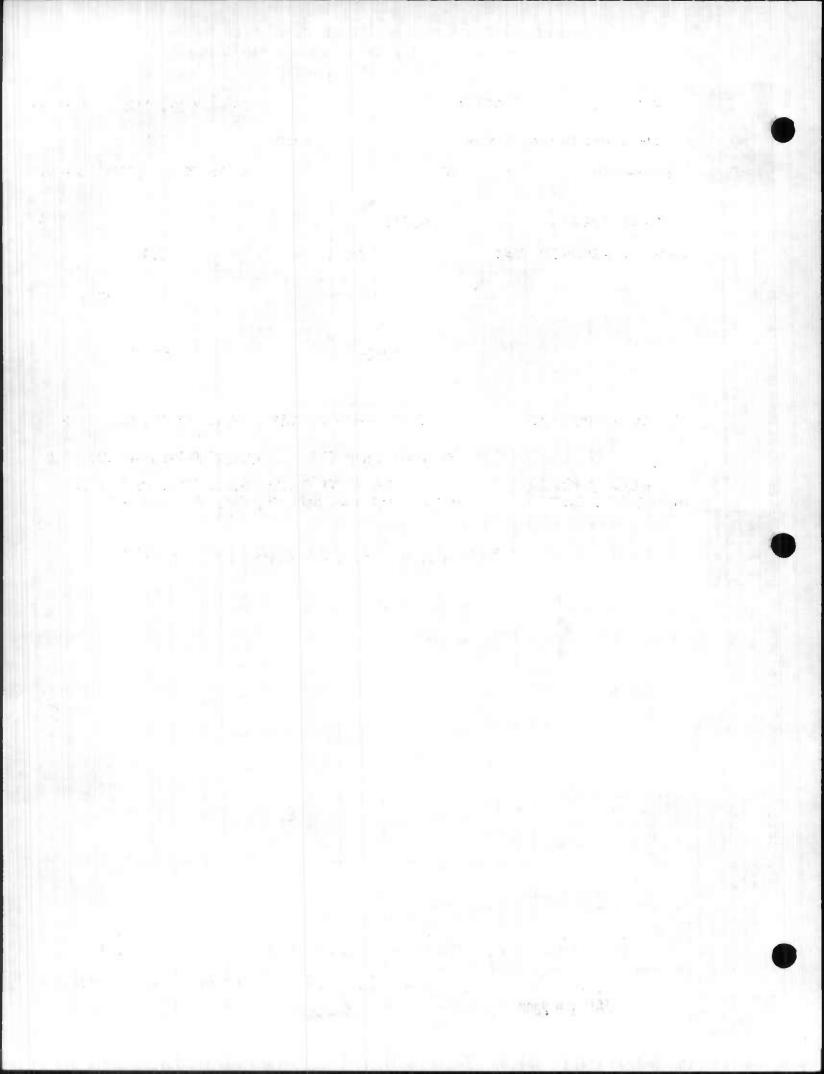
death.



Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 2 2 2 6 Certificate of Death Reg. No. 2. Date of Death Month Pay Year 3. Time of

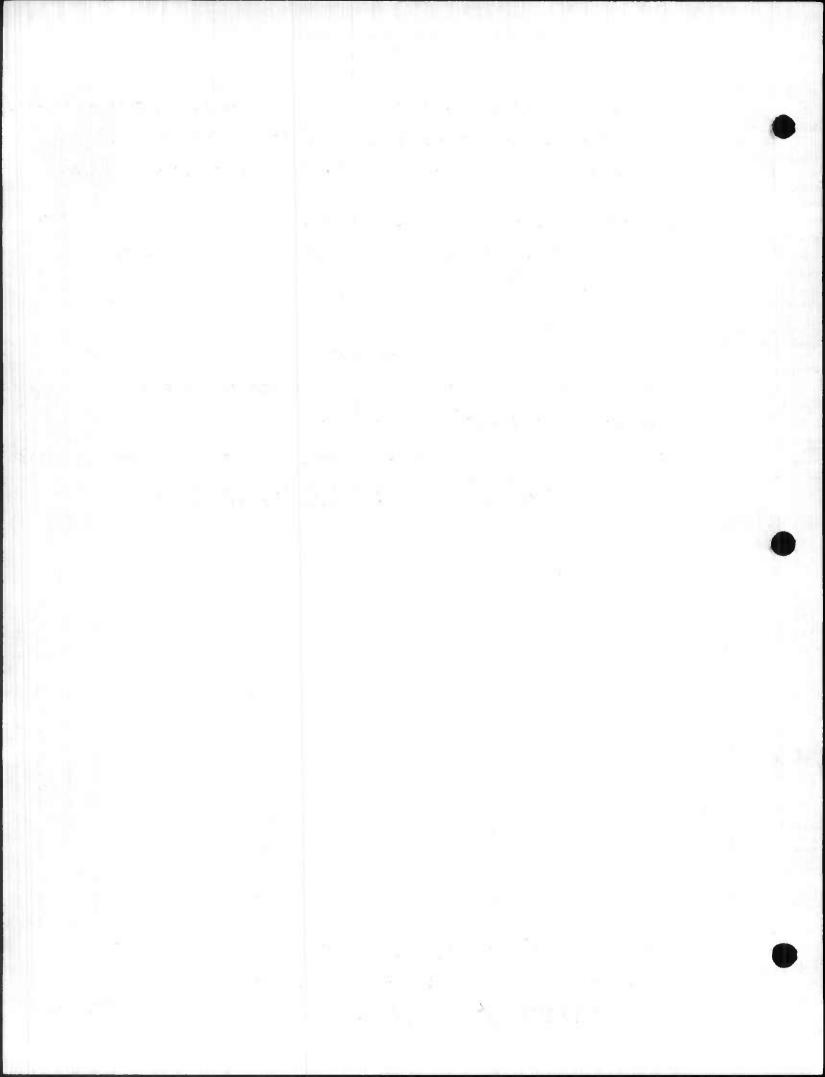
| 1. Decedant's Nama (First, Middla, La | | Cer | | | 2. Date of De | | 3. Time of Death | 1 |
|--|--|--|--|--|--|--|--|------|
| an AGNES B. | CONNOLLY | | | | JANUARY | 17, 20 | 00 5:15 AM | |
| 4a Facility Name (If not institution, give WALDORF HEALTH C | | | | 4b. City, Town, or I | Location of Deatl | 4c. County | | |
| 5. Social Security Number 6. S | | . lest birthdey) | If Under 1 Year | If Under 24 Hrs. | 8. Date of Bir (Month, De | | 9. Birtholace (Stete or Fore | eian |
| 130-14-5840 | 1□M 2√F 90 | | Months Days | Hours Min. | NOVEMBE | R 11, 1 | 909 SCOTLAND | |
| Usual Residence of Decedent | 140.0 | | | | | | Laste to on it | |
| 10a. State 10b. County | | ity, Town or Lo | | | | | 10d. Inside City Lim 1 ☐ Yas 2 🔀 | |
| MARYLAND CHARLES 10e. Street and Number | | WALDORF | 10f. Zip Code | | 1 | 10g. Citizan of V | | |
| 4140 OLD WASHINGTO | ON ROAD | | 20601 | | | U.S.A. | That oodiniy. | |
| MARYLAND CHARLES 10e. Street and Number 4140 OLD WASHINGTO 11. Marital Status 1 Never Married 2 Married | 12. Was Decedent Ever in U | U,S. 13. V | | Hispanic Origin? (S pan, Mexicen, Puart | pecify Yes or No | | e - American Indian, | |
| | Armed Forces? 1 ☐ Yes 2 X No If Yes, Giva | | I Yas, specify Cut I ☐ Yes 2 🗓 No | | o Hican, atc.} | | ck, White, etc. | |
| 3 ♥ Widowed 4 □ Divorced | Yaar or Dates: | | 10 163 2 KINO | эреспу. | | Specify | WHITE | |
| 15. Decedent's E (Specify only highest gre | | (Give | lent's Usual Occu kind of work done DO NOT use retire | during most of wor | king | 16b. Kind of Bu | usiness/Industry | |
| 15. Decedent's E (Specify only highest green properties) Elamantary/Secondary (0-12) 12 | College (1-4or 5+) | | JYER | , | | RETAI | | |
| 17. Father's Nama (First, Middle, Last |) | ВС |) I LIV | 18. Mother's Nar | ne (First, Middle | , Maiden Sumam | | |
| Robert Russell | | | | Margar | et Forr | est | | |
| 19a. Informant's Name/Relationship (| ** | | | t and Number or Ru | rel Route Numb | er, City or Town, | | |
| MICHAEL CONNOLLY/S | | | | LE DRIVE, | | | | |
| 20a. Method of Disposition 1 ☐ Burial 2 🛣 Cramation 3 ☐ | Pamoval from State | cemetery, cren | sition (Nema of natory or other ple | | Date / OO / | | City or Town, State | |
| 4 □ Donation 5 □ Other (Specif | y) I HE | | CREMATO | | | | F, MARYLAND | |
| 21. Signature of Funeral Service Licer | ngood | 22 | Nama and Addr | ess of Facility | HOME | INC DO | CT OFFICE | |
| | | | HE HUNII | FUNERAL | HUME, | INC., PU | SI OFFICE | |
| PAC WOHN P. KNISL | EV MO11 | 64 B | OX 156. | FUNERAL WALDORF | MARYLAN | ND 2060 | 4-0156 | |
| 23a. Part1. Enter the disaase, or com shock, or haart failure. List only | plications that ceused the dea | 64 B | OX 156. | WALDORF. | MARYLAN | ND 2060 | 4-0156 Approximate Interval Batween Onset and Death | |
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State Registrar



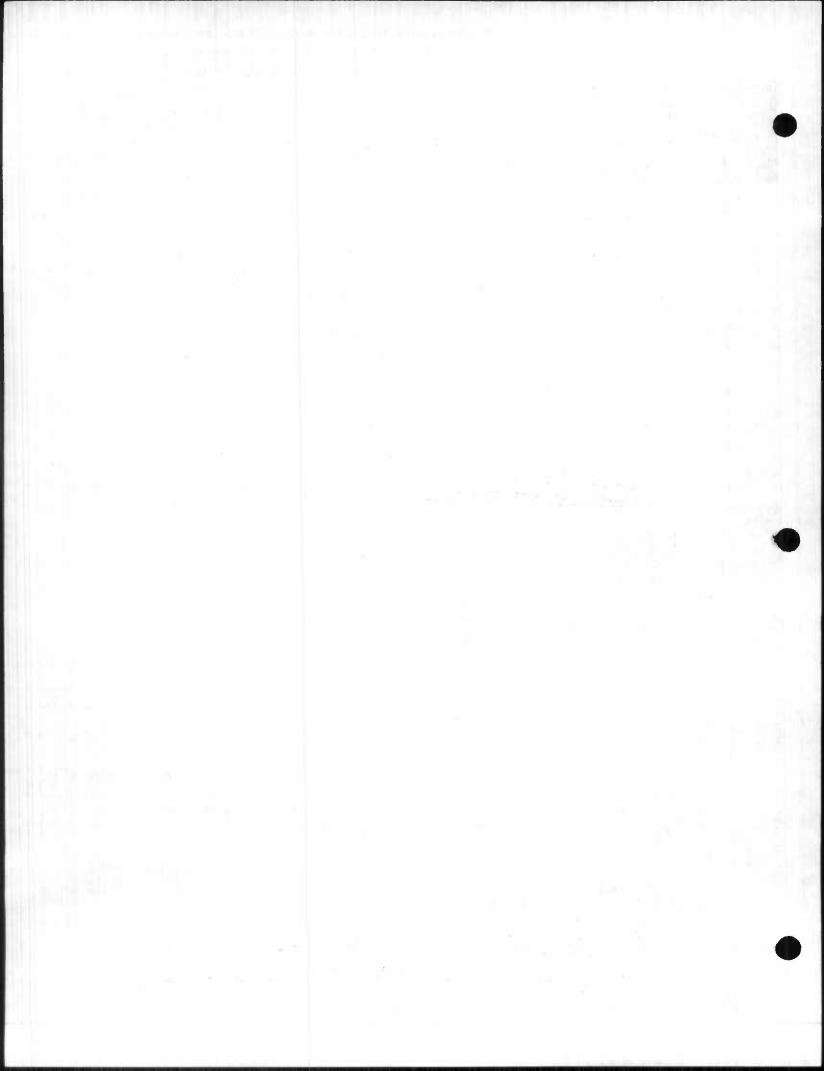
State of Maryland / Department of Health and Mental Hygiene

| | | | | Ce | ertificate | of D | eath | | Reg. N | 0. | | |
|--|----------------|---|--|------------------------------------|--|---------------------|--------------------------------------|--|---------------------------------|------------------------|----------------------------|--|
| Dhualai | ion | 1. Decedent's Name (First, Middle, Last |) | | | | | 2. Date of | D. D. | ву | Year | 3. Time of Deeth |
| Physici /Medi | | GRETCHEN | PERRIE CL | EMENTS | | | | JANU | ARY | 14,2 | 2000 | 6:30 A |
| Examir | | 4e. Fecility Name (If not institution, give $11535 \ \ ST \bullet$ | street and number) MARY 'S CHI | URCH R | OAD | | | m, or Location of I | | | of Deeth | |
| Funeral Director | | 210 00 3317 | X 7. Age (In) | /rs. last birthde 80 Yrs. | | Yeer Deys | If Under 2 Hours | Min. 8. Dete of Month | Birth 1, Dey, Year 19, 19 | 19 | 9. Birthpl MAR | ece (State or Forei |
| pur * | | Usual Residence of Decedent 10e. State 10b. County | 10c | City, Town or I | ocation | | - | | | | 1/ | Od. Inside City Limit |
| se Maryla | Director | MARYLAND CHAR | | | HARLO | | HAL | L | | | | 1 ☐ Yes 2 🙀 N |
| or 2 | Dire | 10e. Street and Number | | | 10f. Zip C | | | | 10g. C | | What Count | • |
| ath v | ral | 11535 ST.MARY'S | | | | | 0622 | | | | S.A. | |
| 72 hours efter death with the Maryland naturel', or flerns 23s or 28=1 show files Examiner must be notified at | by Funeral | 11. Meritel Stetus 1 □ Never Merried 2 □ Merried 3 □ Widowed 4 □ Divorced | 12. Wes Decedent Ever II Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: | n U,S. 13 | . Was Deceder If Yes, specify 1 ☐ Yes 25 | | penic Orig , Mexicen, Specify: | In? (Specify Yes of Puerto Rican, etc | or No- | | ck, White, e | etc. |
| neturel. | | 15. Decedent's Edu | | 16a Dec | edent's Usual (| Occupat | lon | | 16h | Kind of B | usiness/ind | |
| within than | Completed | (Specify only highest gred Elementery/Secondary (0-12) | | (Giv life. | e kind of work DO NOT use | done du retired) | iring most | of working | 100.1 | | | |
| be filed ital Hygie d other event, II | | 12 17. Father's Name (First, Middle, Last) | E | Н | OMEMAR | | 18. Mother | 's Neme (First, M | iddle. Meide | | I HON | TE |
| | Be c | JOSEPH SUMMER | FIFTH DEDI | DTE | | | | ETCHEN | | | , | |
| d 2 should th and Men 7 le marke traumatic | To | 19e. Informant's Neme/Reletionship (Ty | | | ling Address /S | Stroot at | | or Rural Route N | | | Ctoto 7in | Code |
| d d d | | WILLIAM N. CL | | | | | | Or Hurar Houle N | umber, City | or rown, | State, ZIP | C000) |
| of Health Item 27 | | 20e. Method of Disposition | | DA Disi Disi | ME AS | | J | Dete | 200 1 | ocation - | City or To | um State |
| 5 2 2 0 | | 1 Burlel 2 □ Cremetion 3 □ F 4 □ Donetion 5 □ Other (Specify) | temovel from State | cemetery, cr | emetory or other | er plece | | | | | | MARYLA |
| permit. Pege Department of Important: If any injury or once. | | 21. Signeture of Funerel Servica Licans | M00479 | | | ND I | FUNE | RAL SEF YLAND | VICE 2064 | | Α. | |
| _ | | 23a. Pert1. Enter the diseese, or compl | cations thet caused the d | eath. Do not e | nter the mode | of dying, | such es c | ardiec or respiret | | O | - | Approximate |
| Physician | | shock, or heart feilure. List only or | ne cause on eeun ine. | | | | | | | | | Onset and Deeth |
| /Medical | | Immediate Cause (Final | ECODUA | CEAT O | 7 | | | | | | i | |
| Examiner | | disease or condition resulting in death) | ESOPHA | 000 V | | | | | | | | |
| | ē | | D09 (| o (or es e cons | equenca oi): | | | | | | 1 | |
| tificate be executed ig physician and as the burial-transit | Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury | Due to | o (or es e cons | equenca of): | | | | | | 1 | |
| siciar buri | | Cause (Disease or Injury | | 420 0000 000 00 | | | | | | | | |
| certificate be ding physicia ise as the bur | Medical | that initiated events resulting in death) Last | Due to | o (or es a conse | quenca of): | | | | | | | |
| 2 2 3 | lan/ | | J | | | | | | | | | |
| he etter | sic | Part II. Other eignificant conditions con | tributing to death but not | resulting in the | underlying cau | se giver | n Pert I. | 23b. | Did tobacc | o uee co | ntribute to | the cause of deat |
| es that the death igned by the ette be detached for | y Physician | | | | | | | | 1 🗆 Yee | 2□ No | ¾ □ Prob | ebly 4□Unkno |
| ew requires to been so | Completed by | | | | | | | 240. | Wes en autoperformed? | opsy | ava | re autopsy findings Illable prior to apletion of ceuse leeth? |
| The ate h | Son | | | | | | | | 1□ Yes | 2X□ No | 1□ | Yes 2□ No |
| Physicien: The this certificate ral director, page | Be (| 25. Wes case reterred to medical examiner? | | | | | 26. Place | of Deeth (Check of | only one) | | | |
| ysicien: Is certific director, | To | 1 Yes 2 No | lospitel: | ER/Outpatio | ent 3D DOA | Other | 4 □ Nun | sing Home 5/ | Residence | 6 Oth | er (Specify |) |
| F Age | | 27. Manner of Deeth 1 Netural 5 Pending 2 Accident Investigation | 28a. Dete of Injury (Month, Dey Year | 28b. Time Injury | ot 28c | . Injury (Work? | | 28d. Desc | ribe how Inj | | | |
| al or Attending s after death. I Director: After of in by the Esha | Certification: | 3 Suicide 6 Could not be determined | 28e. Plece of Injury - A building, etc. (Spe | t home, ferm, s | treet, fectory, o | ffice | | | on (Street e r Town, Sta | | per or Rural | Route Number, |
| To the Hospital or Attention within 24 hours after deat To the Funeral Director: completely filled in by the | edical (| 29e. Certifier (Check only one) 1 Certifying Physical Examination (Check only one) 2 Medical Examination (Check only one) | ician: To the best of my liner: On the basis of examend menner steted. | knowledge, dee inetion end/or i | th occurred et investigation, In | the time my opi | , dete and nion, deeth | pleca, and due to n occurred et the t | the cause(sime, dete ar | s) and ma nd pleca, | anner as str and due to | ated. the ceuse(s) |
| withi To th | M | 29b. Signeture and title of certitier | | | 29c. L | icense | number | | 29d. D | ete signe | d (Month, L | Dey, Year) |
| | | Moule | M. Ma | the | | 283 | 52 | | JAN | .14 | , 2000 |) |
| | | 30. Name and address of person who co KISHAN MATHUR | ,MD 350 | 0 OLD | | NGT | ON R | OAD WA | LDOR | F,MI | D. 20 | 0602 |
| Sta Registr | _ | JAN 1 8 20 | 32. Registrer's SI | gneture | 4. do | are | 2 | | | | | |



State of Maryland / Department of Health and Mental Hygiene 0 22

| | | | | | , | Ce | rtifica | ate of | Death | F | leg. No. | U | 2660 | |
|---------------------|--|----------------|--|--|----------------------------|--------------------------------|------------------------|-------------------------------------|---|---|----------------------------------|--|--|-----------|
| | Dhamial | 4. | 1. Decedent's Neme (First, Middle, La | ist) | | | | | | 2. Dete of Dee Month | | Yeer | 3. Time of D | eath |
| | Physicl /Medi | | Addie B. | Chamber | .s | | _ | | | January | | 2000 | 10:55 | P.M. |
| | Examir | | 4e. Fecility Name (If not institution, give | A CONTRACTOR OF THE PARTY OF TH | | | | | 4b. City, Town, or | Location of Deeth | 4c. County | of Deeth | | |
| | باللب | ш, | Shore Nursing an | | | | | | Denton | | Carol | | | |
| | Funeral Director | | | Sex I□ M 201/F | ge (In yrs. 94 | lest birthdey Yrs. | Month | der 1 Year ns Deys | If Under 24 Hrs Hours Min | | | | place (State or I ntry) yland | Foreign |
| | ahow ad at | | 10a. State 10b. County | | 10c. Ci | ty, Town or L | ocation | | | | | 1 | 10d. Inside City | Limits |
| | Men I | tor | Maryland Caroli | ne | | Denton | | | | | | | 1 Tes 2 | 2 No |
| d d | deeth with the Meryland rms 23a or 28a-f show r mant be notified at | al Director | 10e. Street end Number 420 Camp Ground | d Road | | | | Zip Code | | 1 | 0g. Citizen of V | What Cour | ntry? | |
| Maryland 21215-0020 | or he | by Funeral | 11. Maritel Stetus 1 Naver Merried 2 Married 3 X Widowed 4 Divorced | 12. Was Decedent Armed Forces 1 Yes 2 17 If Yes, Give Yaer or Datas: | ? | I,S. 13. | | cedent of I pecify Cub 2 M No | | Specify Yes or No- to Ricen, atc.) | 14. Rac | ck, White, | | |
| 5-0 | 72 ho | ted | 15. Decedent's En | ducetion | | 16e. Dece | dent's U | suel Occup | pation | deina | 16b. Kind of B | The state of the s | | |
| 121 | is 1 and 2 should be filed within 72 hours of Health and Mental Hygiene. Ifem 27 is marked other than 'natural', other traumatic event, are Medical Ex- | Completed | Elementery/Secondary (0-12) | College (1-4or | 5+) | life. | DO NOT | Tuse retire | during most of wo | rking | | | | |
| 121 | A transfer | | 6 | | | Home | make | r | T | | | | se's ho | me |
| anc | Half P | Be | 17. Fathar's Nama (First, Middle, Last |) | | | | | | me (First, Middle, | Maiden Sumen | 16) | | |
| 7 | z should be filed v end Mental Hygie la marked other t aumatic event, in | 10 | Thomas 19a. Informani's Neme/Reletionship (| Vilmer | | 10h Mail | in a Addis | /Ct | Mae | und Davida Alumba | | nknov | | |
| Ma | then 7 is t | | | | | | | | | ural Route Numbe | | | | |
| ē. | Health tem 27 other tr | | Samuel Maddox, 20e. Method of Disposition | | 20b. f | Plece of Disp | Hig osition (| h Str Veme of | eet, Che | stertown | , Maryla 20c. Location - | nd 2. | 1620 | |
| OL . | nt: Hite | | 1 N Burial 2 □ Cremetion 3 □ 4 □ Donetion 5 □ Other (Specif | Removel from State | | cemetery, cre w. Chan | | | | 1/11/200 | 0 0010 | | Ma1 - | 1 |
| | permit. Pages 1 and Department of Health Important: If New 27 any injury or other tropics. | | 21. Signeture of Funerel Supplemental | | | | 2. Name | and Addre | ess of Fecility | eral Hom | | man, | maryia | па |
| | 20 5 6 0 | | | | | > | P.O | . Box | 1687. Ea | ston. Mar | vland 2 | 1601 | | |
| P | hysician | | 23e. Pert1. Enter the disease, or com shock, or heert feilura. List only | plications that ceuse one ceuse on each ! | d the deel ine. | th. Do not en | ter the m | node of dyl | ng, such es cerdla | c or respiratory arr | est, | | Approximete Intervel Betwe Onsat and De | en eth |
| | /Medical | | fmmediate Ceuse (Finel disease or condition | | | | W G G | cup s | 21.5 | | | 1 | luk | march |
| " | Examiner | L | resulting In deeth) | 0. | Due to (| or es e conse | | | | | | | | |
| 7 | S is | nlne | | b | | | | | | | | | | |
| | cate be executed physician end sthe burief-transit | Examiner | Sequentially list conditions, if any, leading to immediate | | Due to (| or es e conse | quance c | of): | | | | | | |
| 68760, | siciar buri | | ceuse. Enter Underlying Ceuse (Diseasa or injury that initiated events | C | Due to /s | or es e conse | Tuenes of | .s\. | | | | | | |
| × 68 | 0.0 | /Medical | resulting in deeth) Last | d | o) of edd | as a consen | quence o | n). | | | | | | |
| Вох | death ce e attendi ed for use | Physician/ | | | | 4 | | | | | | | | |
| 0 | the or | hysi | Pert II. Other significant conditions of | ontributing to death t | out not ras | ulting In the u | ınderlyin | g ceusa gi | ven in Pert f. | | | | o the cause of | |
| Д. | es that the death ce igned by the attendi be deteched for use | by P | | | | | | | | 1 U Y | es 22No | 3 Pro | Dably 4 ∐ Ur | nknown |
| Records, | been s | Completed t | | | | | | | | 24e. Wes a perfor | | ev | ere eutopsy find alleble prior to empletion of ceu deeth? | |
| | ysician: The lav s certificate has director, page 2 | mo/ | | | | | | | | 1 🗆 Y | as 2 No | 1[| ☐Yes 2☐N | lo |
| /ita | artifica ctor, | Be (| 25. Wes cese referred to medicel examiner? | | | | | | 28. Place of De | eth (Check only or | (6) | | | |
| of Vital | 00 | 2 | 1 ☐ Yes 2 ☐ No | | | ER/Outpatie | nt 3□ | DOA | | Home 5 Reside | ence 6 Oth | er (Specif | <i>(y)</i> | |
| ion | Attending Price death. | ation: | 27. Menner of Deeth 1 Returel 5 Pending 2 Accident Investigation | 28a. Dete of Inju (Month, De | y Year) | 28b. Time o Injury | of M | 28c. Inju Wo 1 [| ryat rk? Yes 2 ⊡ No | 28d. Describe h | ow Injury occur | red | | |
| 5 | i Die | Certification: | 3 ☐ Suicida 6 ☐ Could not b determined | e 28a. Place of In building, ei | jury - At h lc. (Specil | ome, farm, st | reet, fect | ory, office | | 28f. Location (Si City or Town | | er or Rurs | il Route Numbe | 91, |
| House | 24 hours Funeral letely filled | edical (| 29e. Certifier (Check only one) Certifying Ph | ysician: To the best ninar: On the besis of end mennar st | f axemina | wledge, deet tion and/or In | h occurre vestigeti | ed et the ti | me, dete and place ppinion, deeth occu | a, and due to the curred et the time, d | euse(s) end me ete end place, | nner es s end due to | teted. the ceuse(s) | |
| | within 2 To the comple | Me | 29b. Signeture end title of certifier | | | | 2 | 29c. Licens | se number | 2 | 9d. Dete signe | d (Month, | Dey, Year) | |
| | 2 - 0 | | 2 U Xu | CMI | | | | 11.7 | 1036 | | 1/7/ | 00 | | |
| | | | 30. Name and address of person who | completed cause of | ate (Iter | - | Print) | | | uh m | 711 | . 0 | | |
| | | | 31. Data filed (Month, Dev. Year) | 32. Regist | 0 | - | 1200 | the by | w Ch | nm w | 1 2/6 | 17 | | |
| | Sta Registr | | JAN 1 2 7 | | President | | 1 | Ina | 1.1 | | | | | |

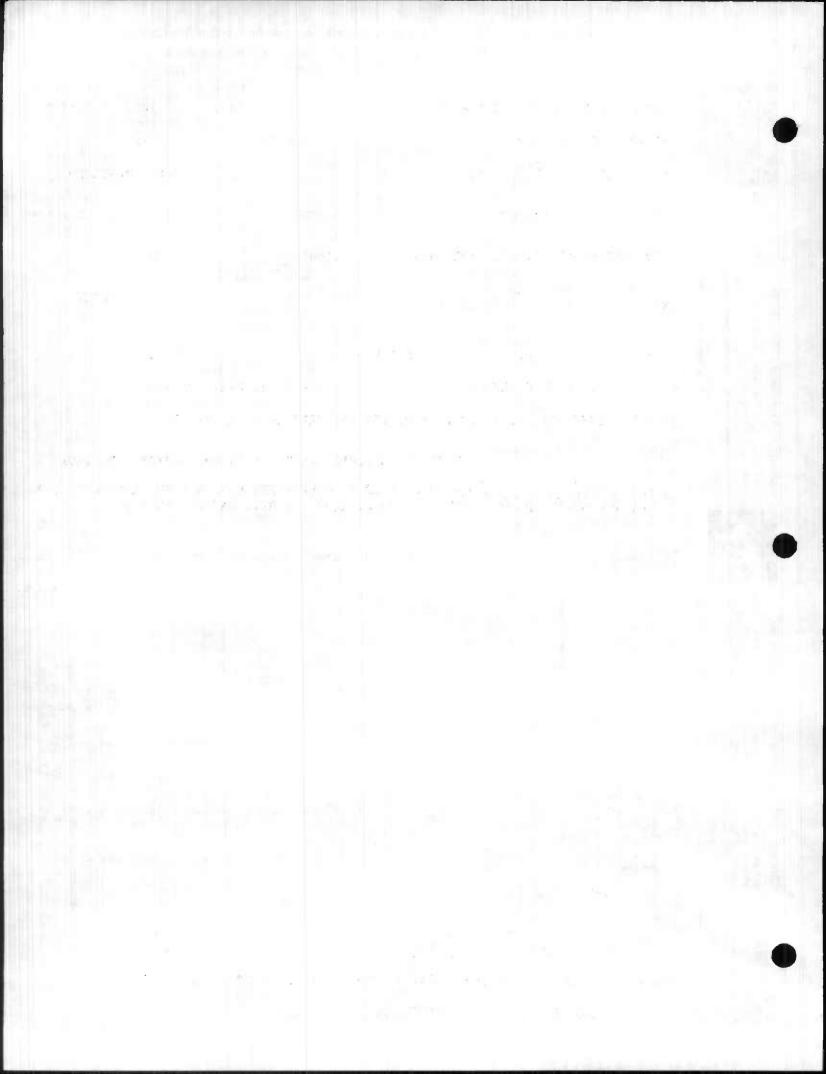


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician HARRY CARROLLTON CHALMERS JAN. 12, 2000 5:42 PM /Medical 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** TALBOT HOSPICE HOUSE EASTON TALBOT 6. Sex 1XXM 2□ F If Under 1 Year If Under 24 Hrs. Birthplace (Stete or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) **Funeral** Months Deys Hours Yrs 81 216-07-0123 **Director** FEB.18, 1918 MARYLAND Usuai Residence of Decedent with the Maryland 10a Stete 10b. County 10c. City, Town or Location 10d. fnside City Limits item 27 is marked other than "natural", or itema 23a or 28a-f show other trsumatic event, the Medical Exercises must be notified at MD TALBOT EASTON 1 Yes 2 No Director 10f, Zip Code 10g. Citizen of Whet Country? 10e. Street and Number 640 MECKLENBURG AVENUE, APT. 304 21601 USA Funeral death 12. Was Decedenf Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yea or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours effer. Department of Heelth end Mental Hygiene. Important: If item 27 is marked other than "natural", or has any injury or other traumatin. 1XWes 2□No If Yes, Give Year or Dates:WW II 1 Never Married 2 Merried Maryland 21215-0020 1 Yes 2 No Specify: Specify: WHITE à 3 Vidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuei Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementery/Secondary (0-12) PRESSMAN PRINTING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) WILLIAM MacMILLEN CHALMERS LILLIAN PEARL SAUNDERS 10 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) JOAN M. TOMS/ EST. PERS. REP. P.O. BOX 56, BETHLEHEM, MD 21609 altimore, 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 20e. Method of Disposition Burial 2 Cremation 3 Removal from Stafe
4 Donetion 5 Other (Specify) WOODLAWN MEMORIAL PARK 1-15-00 EASTON, MD 21601 21. Signature of Funeral Service Licenses 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 200 S. HARRISON ST., EASTON, MD 21601

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Intervel Between Onset end Death **Physician** Immediate Ceuse (Final disease or condition resulting in deeth) /Medical GUAMOUS CELL CARCINGMA OR MONTH Examiner Due to (or as a consequence of): Examiner COSTAR CARCINO. certificata be executed attending physician end for usa as the bunel-tran Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Box 68760. Physician/Medical Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 94 2 1 Yes 2 No 3 Probably 4 Hiknown þ 8 24b. Were autopsy findings evallable prior fo completion of cause of deeth? 24a. Wes an autopsy performed? Completed has 1 Yes 2 No 1 ☐ Yes 2 ☐ 1No certificata Division of Vital 25. Was case referred to medical examiner? Be 26. Plece of Death (Check only one) Other: 4 | Nursing Home 5 | Residence 6 Dether (Specify) Hospic & 1 Yes 2 No 10 1 Inpatient 2 ER/Outpetient 3 DOA this funeral 28d. Describe how injury occurred 27. Menner of Deeth 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? Certification: After 5 Pending investigation Hospital or Attending 1 Neturel 1 Yes 2 No 2 Accident after deetl Director: 6 Could not be determined 3 Suicide 28e. Placa of injury - At home, farm, sfreet, factory, offica building, etc. (Specify) 28f. Location (Street end Number or Rurei Route Number, City or Town, Stete) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner es stated 29a, Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and plece, and due to the cause(s) within 2 To the end manner stated. \$ 29b. Signature and fitte of cartifier 29c. License number 29d. Date signed (Month, Dev. Year) 0 D31466 941 30. Neme and address of person who computed cause of deeth (Item 23a) (Type, Print) LUDWIG J. EGLSEDER, III, M.D., 606 DUTCHMAN'S LANE, EASTON, MD 21601 31. Date filed (Month, Day, Year) 32. Registrer's Signeture State JAN 14 2000 b ooks Registrar

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Month JANUAR 2000 1:50 PM EDNA M. CHISHOLM 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death

7. Age (In yrs. last birthday)

10c. City, Town or Location

Landover

60

12. Wes Decedent Ever in U,S. Armed Forces?

1 ☐ Yea 2 ☑ No If Yes, Give Year or Dates:

College (1-4or 5+)

1□M 2♥F

10b, County

15. Decedent's Education (Specify only highest grade completed)

Willie Joe Sheppeard

12

Lanham

Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Cora

10245 Prince Place, #208, Largo, MD

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code)

If Under 1 Year | If Under 24 Hrs. Months Deys Hours Min.

Deys

20785

1 Yes 2 No Specify:

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Supervisor (Best Western)

10f. Zip Code

Physician /Medical Examiner DOCTORS COMMUNITY HOSPITAL 5. Social Security Number **Funeral** Director 050-52-1578 Usuel Residence of Deced 10a. Stete must be notified at Directo Maryland Prince George's 10e. Street and Number Norms 23a 504 Pacer Drive 11 Marital Status 1 Never Merried 2 Married "natural", or 3 ₩ Widowed 4 Divorced Hyglene. Hyglene. Ther then "n Elementery/Secondary (0-12) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be hent of Health and Mental 19a. Informent's Neme/Relationship (Type, Print) opartment of Health Important: If health any Injury or other 27 is any Injury or other Jacqueline Stephens - Daughter

Physician /Medical Examiner

physician and the burial-transit or Attending Physician: this r death.

Examiner Physician/Medicai þ Completed Be Certification: To edicai

68760 Box O 0 Records. of Vital Division n 24 hours after death, he Funeral Director: After the funeral or the function of the function of the funeral or the function of the funeral or the function of the function o Hospital To the Hosp within 24 hou To the Fune completely fi

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print) JC Shesadni 31. Date filed (Month, Day, Year) JAN 1 4 2000 Registrar

MD

MD

29c. License number D53411 29d. Date signed (Month, Day, Year) Janvary

134 2000 Bowle 20708

3. Time of Death

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 Ves 2 No

Washington, D.C.

Prince George's

10g, Citizen of What Country?

16b. Kind of Business/Industry

United States

14. Race - American Indian,

Black

Bleck, Whita, atc.

8. Date of Birth (Month, Day, Year)

Nov. 27, 1939

18. Mother's Name (First, Middle, Meiden Sumame)

(Unknown)

3060 unitabellville Re # 103 32. Registrar's Signature

ORIGINAL

DHMH 16 Rev 6/95

20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) Harmony Memorial Park 1/15/2000 Landover, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility STEWART FUNERAL HOME, Inc. 4001 Benning Road, N.E., Washington, D.C. 20019 23a Put1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrast, blick, or heart tailure. List only one cause on each line. Approximata Intervel Between Onset and Deeth Immediate Cause (Finel Lintra cramial disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown Unos eminated Intravarantar angulapulty 24a. Wes en eutopsy performed? 24b. Were autopsy tindings evailable prior to Hematuria completion of cause of death? gastro intotind wwer 1 Yes 20 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, ferm, atreet, fectory, office building, etc. (Specify) 4 ☐ Homicide 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) end menner as atated.

2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, deeth occurred at the time, date and place, end due to the cause(s) and manner stated. 29a. Certifier (Check only 29b. Signeture and the of certifier

MAN I WILL STATE S

ANTHONY D. CARTER

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

00 0223

1. Decedent's Nama (First, Middle, Last) 3. Time of Death 2 Date of Death 2000 Month **Physician** 9, ANTHONY DAVID CARTER JAN. 0143 AM /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7701 VANDUSEN ROAD LAUREL PRINCE GEORGES 5. Social Security Number 213-94-7016 If Under 1 Yaar | If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) SEPT. 19, 9. Birthplace (State or Foreign Country) 9. MARYLAND 7. Aga (In yrs. last birthday) **Funeral** Months Days Hours 101 X 20 F 20 Yrs. 1979 Director Usual Rasidanca of Decedant 10b. County 10c. City, Town or Location 10d. Inside City Limits MARYLAND PRINCE GEORGES BLADENSBURG XX Yas 2 No Director Home 23s or 28s-f must be notifi 10g. Citizan of What Country? 10e. Street and Number 10f. Zip Code 5215 NEWTON ST. #T-3 20710 UNITED STATES Funeral 12. Was Decedent Evar in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Raca - Amarican Indian, Black, Whita, atc. 72 hours after 1 ☐ Yas 為XNo If Yas, Giva Yaar or Datas: XX Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 Yas XX No Specify: by SEFRO-AMERICAN 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) Collega (1-4or 5+) CARPET INDUSTRY CARPET CLEANER 11TH 18. Mothar's Nama (First, Middle, Malden Sumame) 17. Fathar's Nama (First, Middle, Last) Mental 2 JOHN DAVID BROWN BRENDA MINOR 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) permit. Pages 1 and 2 st Department of Health and Important: If then 27 is in any Injury or other traum 9058. ä BRENDA MINOR CARTER/MOTHER 5215 NEWTON ST. #T-3, BLADENSBURG, MD 20710 20b. Placa of Disposition (Name of Data 20a. Mathod of Disposition 20c. Location - City or Town, Stata Cemetery, crematory or other place)
GLENWOOD CEMTERY JANUARY 14, 2000 1 XX Surial 2 Cramation 3 Ramoval from Stata WASHINGTON, D.C. 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Fune al Service Licensae 22. Nama and Addrass of Facility mund DUDLEY FUNERAL HOME DUBLEY MT. RAINIER, MD 20712 EDWARD M. 3200 RHODE ISLAND AVE., Second Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediata Causa (Final diseasa or condition rasulting in death) Gunshot Wounds Examiner Due to (or as a consequence of) Physician/Medical Examiner the attending physician end hed for use es the burial-transit Sequentially list conditions, if any, leading to immadiata cause. Entar Undarlying Cause (Disaase or injury Dua to (or as a consequanca of): The law requires that the death certificate be execu Box 68760. that initiated avants Dua to (or as a consequence of): rasulting in death) Last 23b. Did tobacco use contribute to the cause of death? P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown by Division of Vital Records, 24b. Wara autopsy findings available prior to completion of cause of death? Completed 24a. Was en autopsy performed? hes Yas 2 No Vas 2 No Physician: Be 25. Was casa rafarrad to medical axaminar? 26. Placa of Death (Check only ona) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Rasidenca 6 POther (Specify) AT SCENE XXYas 2 No 2 this eral Director: After thi filled in by the funeral 28a. Data of Injury (Month, Day Year) 28d. Dascribe how injury occurred 27. Mannar of Death 28b. Tima of Injury Certification: 28c. injury at Work? i or Attending P 5 Pending invastigation 1 Natural 1-9-00 subject shot 0127AM 1 Yas 2 2No 2 Accident 281. Lobdion (Street and Number or Rural Floute Number, City or Town, State) 7 701 Vandusen Koul 6 ☐ Could not be 3 ☐ Suicida 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicida Street To the Hospital within 24 hours a To the Funeral Completely filled Laurel, Hd 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and piece, and due to the causa(s) and mannar as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and mannar stated. Medical 29a. Cartifier 29c. Licansa number 29d. Data signed (Month, Day, Year) 29b. Signatura and titla of certifian JAN. O.C.M.E 9, 2000 hurs. Lema complated causa of daath (Item 23a) (Type, Print) 30. Nama and addrass of person who 111 Penn Street, Baltimore, Maryland 21201 stem ennis

DHMH 16 Ray 6/95

Registrar

31. Data filed (Month, Day, Year)

JAN 1 2 2000

32. Registrar's Signatura

3007 . 401

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Tima of Death Month **Physician** 1, 2000 9:11am Harold A. Collins, Jr. January /Medical 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Prince George,s Clinton Hunder 24 Hrs. 8. Data of Birth (Month, Day, Year) (Country)
Oct. 30, 1933 Baltimore, Md. If Under 1 Year 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1⊠ M 2□ F Yrs. 66 Director 219-30-0421 Usual Residence of Decedent 10a. Stata 10b. County 10c. City. Town or Location 10d. Inside City Limits or 28s-f show Maryland Prince George's Bowie 1 X Yas 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 238 20716 United States 16010 Excalibur Rd. #D207 Funeral Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Wes Decedant Evar in U.S. Armed Forcas? 72 hours after 1 ⊠ Yas 2 □ No If Yes, Giva Yaar or Datas: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 b Specify: Black 1 ☐ Yes 2 ☑ No Specify: P 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within Elementary/Secondary (0-12) College (1-4or 5+) Vendor Private 11 17. Fathar's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Mental Important If New 27 is merked or any Injury or other traumatic eve Harold A. Collins, Sr. Mary J. Haywood 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16010 Excalibur Rd. #D207 Bowie, Md. Corrine V. Collins/Wife 20a. Mathod of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, Stata Date cemetery, crematory or other place) 1 ☐ Buriel 2 ☐ Cramation 3 ☐ Removal from Stata 1/8/00 Beltsville, Md. 4 ☐ Donation 5 ☐ Othar (Specify) Chesapeake Crematory 21. Signatura of Funaral Sarvice Licensee 22. Name and Address of Facility
Alexander S. Pope Funeral Homes 071085 5538 Marlboro Pike/Forestville, Md. 20747 23a. Part1. Enfar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediata Causa (Final disaasa or condition resulting in daath) /Medical 30045 SHOCK Examiner Due to (or as a consequence of): Examiner EP\$15 MULTIPLE Sequentially list conditions, if any, laading to immadiata causa. Entar Underlying Cause (Disease or Injury that initiated evants rasulting in death) Last Dua to (or as a consequence of): physicien s the burial P.O. Box 68760, Physician/Medical Due to (or as a consequence of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Nuknown signed be det Records, by Completed 24b. Were autopsy findings available prior to completion of cause of death? Seizure disordy. 24a. Was an autopsy 1□ Yes 2010 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: funeral director, Be 25. Was casa rafarred to medical axaminar? 26. Place of Death (Check only one) Hospitel: 1 Donpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yas 2 No After this 28a. Dete of Injury (Month, Day Year) 27. Mannar of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending 24 hours after death. Funeral Director: Al 1 Yes 2 No Investigation 2 Accidant 6 Could not be datarmined 3 Suicida 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicida Hospital 1 Certifying Phyaician: To the best of my knowledge, deeth occurred et the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifiar Medicai pletely (Check only one) within 2 To the To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signatura and titla of certifier 1-2.2000 D46478 30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print) Surratts Rel # 307 clinton MD 20737 A. Putumo 7501 Suresh 31. Date filed (Month, Dey, Year) 32. Registrar's Signeture State

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Registrar

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State of Maryland / Department of Health and Mental Hygiene () () () ()

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| uneral rector | C | 5. Social Security 043-07-50 | 368 | Sex 1□M 2Å F | 7. Age (In yrs. 85 | last birthday) Yrs. | If Under 1 Months I | Year Days | H Under 2 Hours | 24 Hrs. Min. | 8. Date of Bir (Month, Da JUNE 2 | th vear | 14 | 9. Birthpli CAMI | EN, SO |
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Tima of Death 1. Decedent's Name (First, Middle, Last) JANUARY 7, 2000 ear **Physician** 7:19pm FREDY CARTER /Medical 4a Facility Name (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner CHEVERLY PRINCE GEORGES PRINCE GEORGES HOSPITAL If Under 1 Yaar If Under 24 Hrs. 8. Date of Birth
JUNE 8, 1940 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1♥M 2□F Months Days Hours Min. SUMTER, SC 247-70-3681 59 Yrs. Director Usuai Residence of Decedent 20 1/19 10c. City, Town or Location 10d. Inside City Limits 10a Stata 10b. County r 28a-f show 1 XYes 2 No RIVERDALE PRINCE GEORGES Director the 1 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code permit. Peges 1 and 2 should be filed within 72 hours effer death with 1 Dependment of Health and Mental Hygiene. Important: if item 27 is marked other than "naturel", or itema 23a or 3 en/ in lury or other traumatic event, the Medical Exemptor must be a policy. 20737 UNITED STATES 5805 RAVENSWOOD RD Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No If Yes, Give Yaar or Datas: Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, atc.) 14. Race - American Indian Black, Whita, atc Specify: BLACK 1 Nevar Married 2 Married 1 ☐ Yes 2 ☐ No Specify: à 3 Widowed 4 Divorced Completed 18b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade complated) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Coilege (1-4or 5+) PRIVATE TRANSIT OPERATOR 18 Mother's Name (First, Middle, Maiden Surnama) 17. Father's Name (First, Middle, Last) MOZELLE MOSS FREDY CARTER SR. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) BARBARA CARTER / WIFE 5805 RAVENSWOOD RD, RIVERDALE, MD 20737 20b. Place of Disposition (Nama of cemetery, crematory or other place) 20c. Location - City or Town, Stata 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 1-14-00 LANDOVER, MD HARMONY MEMORIAL PARK 4 Donation 5 Other (Specify) 22. Nama and Address of FIDER S. POPE FUNERAL HOME 111043 5538 MARLBORO PIKE, FORESTVILLE, MD 20747 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in deeth) RENAR FAILURE /Medical Examiner Due to (or as e consequence of): Examiner END STAGE RENAL DISEASE law requires that the death certificete be executed physician and s the bunal-transit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical Due to (or as a consequence of): for use as 23b. Did tobacco use contributa to the ceuse of death? signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown HYPERTENTION by 24b. Were autopsy findings available prior to 24a. Was an autopsy Completed SIP CORONARY ARTERY BYDASS GRAFT completion of ceuse of death? certificate has t 1 Yes 2 No 1 TYes 2 No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifical stelly filled in by the funeral director, 25. Wes case referred to medical examiner? Be 28. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) Hospital: 1 ☐ Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Menner of Death 28d. Describe how Injury occurred 28b. Time of 28c. Injury et Work? Naturai 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Sulcide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 D Homiclde To the Hospital or within 24 hours aft To the Funeral Di completely filled in Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and menner as stated.

2 Medical Examinar: On the basis of examination end/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only one) 29c. Licansa number 29d. Date signed (Month, Day, Year) 29b. Signatura and title of certifier k. mahagar mo 2000 D50689 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State 31. Date filed (Month, Day, Year) ISTRAT JAN 1 2 2000

32. Registrar's Signature

ANILK. MAMAJAN PGHOSPITAL 3001 HOSPITAL DR CHEVERLY MD 20185

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) JANUARY 06, 2000 2302 Ann N. Cater 4b. City, Town, or Location of Death 4c. County of Death 4a Fecility Name (If not institution, give street and number) CHNTON SOUTHERN MARYLAND HOSPITAL PRINCE GEORGES Birthplaca (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Months Deys Min. 1 □ M 2 🕅 F Hours Omaha, Nebraska Mar.14,1936 63 577-44-8113 Usuai Residenca of Decedent 10e Stete 10b County 10c City Town or Location 10d. Inside City Limits 1 Yes XX No Maryland Charles Waldorf 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 20601 USA 1118 Falmouth Road 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Maritei Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elamantary/Secondary (0-12) Coliage (1-4or 5+) 12th Parimutuel Teller Horseracing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pau1 Nowell Alice Ann MacGregor 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Robert B. Cater/Husband Same as item 10 20b. Place of Disposition (Name of St. Peter's Church Cemetery 1/10/00 Waldorf, Md. 20a. Method of Disposition 20c. Location - City or Town, State 15 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Neme end Address of Facility George P. Kalas Funeral Home, P.A. 21. Signature of Funeral Service Licenses 6160 Oxon Hill Rd. Oxon Hill, Md. 20745 ter the disease or complications that caused the death. Do not enter the mode of dying, such as ca heart failure / List only one cause on each line. Approximate Intarvai Between Onset and Death Immediate Cause (Final · ARTERIOS CLEROTIC CARDIOVASCULAR DISFASE disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate causa. Entar Undarlying Cause (Disease or injury thet initiated events resulting in death) Last Due to (or as e consequence of): Due to (or es a consequenca of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 4 Unknown 1 Yes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24e. Was en autopsy 2 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No 26. Piaca of Daath (Check only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 SER/Outpatient 3 DOA 1 Inpatient 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

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Certification:

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7 is marked other than "naturel", or itema 23e or 28a-f show treumstic event, the Medical Examiner mast be notified at

the Maryland

Appenit. Pages 1 and 2 should be filed within 72 hours after deat the portant: If them 27 is marked other them any higher or other trainers.

25. Was case referred to medical examiner? Yes 2 No 27. Manner of Death 1 Naturai 2 Accidant 3 Suicide

6 Could not be 4 Homicide

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Cartifiar

1 Certifying Physician: To the bast of my knowledge, death occurred at tha tima, date and placa, and due to the cause(s) and mannar as stated.

Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the tima, date and placa, and due to the cause(s) and manner stated.

29b. Signatura and title of certifie

29c. License number OME

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed MARIO F. GOL

31. Date filed (Month, Day, Year) JAN 1 1 2000

HOSPITAL PRIVE, CHEVERLY, MARYLAND 20785 32. Registrar's Signature

ause of daam (I)em 23a) (Type, Print)

DHMH 16 Rev 6/95

Registrar

To the Hospital e-within 24 hours a To the Funerel D

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1 - STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG NO.

| | REGISTRAR | | CE | KIIIFI | CATE C | F DEATH | | REG. NO | | | |
|------------------------------------|--|--|--|--|--|--|--|---|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | | | E OF DEATH | | | 3. TIME OF DEATH |
| | Dominick John | Corso | | | | | Jani | uary 7 | 200 | OYEAR | 3:00 p M |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last | birthday) | IF UNDER 1 YEA | R IF UNDER 24 HRS. | 7. DATA | OF BIRTH | | | IPLACE (State or Foreign |
| | 228-05-4484 | 1 🕅 M 2 🗆 F | 85 | YRS. | MONTHS DAY | B HOURS MIN. | Mar | ch 11, | 101/ | Countr | y) |
| | 9a. FACILITY NAME (If not institution, give | street and number) | | | 9b. CITY. TOW | N OR LOCATION OF I | | CII II, | | NTY OF D | J |
| œ | Bowie Health Car | • | | | Bowie | N ON COUNTON OF | JEANN | | | | |
| 5 | RESIDENCE OF DECEDENT | Center | | | powie | | | | Prin | ce G | eorge's |
| Œ | 10e. STATE 10b. COUNT | - | | 10c. CITY | , TOWN OR LO | CATION | | | | | 10d. INSIDE CITY |
| DIRECTOR | Maryland Prince | ce George | s | Dav | idsonv | ille | | | | | LIMITS? |
| 7 | 10e. STREET AND NUMBER | | | | | 10f. ZIP CODE | | | 10a, CIT | ZEN OF V | VHAT COUNTRY? |
| FUNERAL | 3767 Patuxent Cro | ossover | | | | 21035 | | | U.S | | |
| N | 11. MARITAL STATUS | 12. WAS DECEDENT | FEVER IN U.S. ARM | ED | 13. WAS I | DECENDENT OF HISPA | NIC ORIGI | N? (Specify Vec | | | E — American Indian, |
| | 1 Never Married 2 Married | FORCES? 1 IF YES, GIVE W | YES 2 NO | | If yes, | specify Cuben, Maxic | an, Puerto | Rican, etc.) | | Black | c, White, etc. |
| BY | 3 Widowed 4 Divorced | 11 120, 0112 10 | AN ON DATES | | , , | ES 2 NO Spec | ary: | | 1 | Speci | White |
| | 15. DECEDENT'S EDI (Specify only highest grad | CATION | 16a. DEC | EDENT'S | USUAL OCCUP | ATION | 16 | b. KIND OF BUS | SINESS/INE | DUSTRY | |
| 4 | Elementary/Secondary (0-12) | College (1-4 or 5 + | Altho I | o NOT us | ork done during a retired.) | most of working | | | | | 4.13 |
| 호 | 8 | | Che | f | | | Re | estaura | nt I | ndus | trv |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | | | | | 18. MOTHER'S N | | | | | |
| BE C | Salvatore Emilio | Corso | | | | Rosina | Vizz | zi | | | |
| | 19a. INFORMANT'S NAME (Type/Print) | | 19b. | MAILING | ADDRESS (Stre | et and Number or Rura | Route Nun | ober. City or Town | n. State. Zic | Code | |
| 2 | Christina E. Step | p: Daught | | | | Drive, A | | | | | 21403 |
| | 20a. METHOD OF DISPOSITION | | 20b. PLACE AN | ND DATE O | FDISPOSITION | | | TE 20c. LO | | | |
| 1 | 1 N Buriel 2 Cremetion 3 Ren 4 Donation 5 Other (Specify) | novel from State | Mount | Oliv | et Cem | etery 01 | | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LI | CENSEE | 4 | ULL | | AND ADDRESS OF F | | | | | |
| | D71 0 1 | Har | 1 | | | | | | | | |
| _ | 1 Constance | 2 /000 | | | 4739 | Baltimo: | re Av | renile | Hvat | terri | 11e. MD |
| | 22 DARW I February discussion | | | | 173. | | | cirae, | 11,00 | COVI. | ric, III |
| | 23. PART I. Enter the diseases, or shock, or heart fellure. | complications that List only one caus | caused the dea | th. Do n | ot anter the | mode of dying, eu | ch ae cer | dlac or reepi | ratory em | eat, | Approximate |
| | immediate cause (Fine) | List only one caus | se on each line. | | ot anter the | mode of dying, eu | ch ae cer | diac or reepi | ratory em | eat, | |
| | shock, or heart fellure. | List only one caus | se on each line. | | ot anter the | mode of dying, eu | ch ae cer | diac or reepi | ratory em | eat, | Approximate interval Between |
| | immediate cause (Finel disease or condition | List only one caus | se on each line. | | ot anter the | mode of dying, eu | ch ae cer | diac or reepi | ratory em | reat, | Approximate interval Between |
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| ATION | IMMEDIATE CAUSE (Finel disease or condition resulting in deeth) Sequentially list conditions, if any, leading to immediate | e. THORA DUE TO (| 4CIC ACORSEON TO REG | PRTTO JENCE OF | ANE | TURYSMA | ch as cor L K lew | diac or reepi | ratory em | reat, | Approximate interval Between |
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the house later death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral direction, page 5 should be defacted for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HO TO THE FU TO THE FIND MAPORTMI ** 10.

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legibie.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death **Physician** COLAJE2 ECMA /Medical 4a Facility Neme (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner Cherrywood Manor Extended Care Centre Reisterstown Carroll 7. Age (In yrs. last birthdey) If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) Jul 15,1917 9. Birthplace (State or Foreign Country) West Virginia 5. Social Security Number **Funeral** Days Months Hours 1 □ M 280 F 216-03-4201 Yrs. 82 Director Usual Residence of Decedent the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits iral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 1 No Director Maryland Carroll Hampstead 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4410 Sycamore Drive 21074 USA Funeral death 11 Marital Status 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: if Itam 27 is marked other than "natural", or fren any injury or other traumatic event, the pre-Black, White, etc. 1 ☐ Yes 2 No 1 Never Married 2 Merried altimore, Maryland 21215-0020 1 ☐ Yes 2X No Specify: White Specify ò 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Own Home Housewife 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Jacob Bohrer Laura Crouse 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Calvin Colajezzi, son 4410 Sycamore Dr, Hampstead, MD 21074 20b. Ptece of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2X Cremetion 3 ☐ Removel from Stete Carroll Cremations 4 ☐ Donetion 5 ☐ Other (Specify) 1/11 Hampstead, MD 21. Signeture of Funerel Service Licensee 22. Neme and Address of Facility MO0723 Eline Funeral Home 934 South Main St, Hampstead, MD 21074 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** THENOSCIEROTUEANDIO MECNEAN DIS /Medical Immediate Cause (Fine) disease or condition resulting in death) Examiner Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of): Box 68760. 94 Due to (or as a consequence of) P.O. Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco usa contributa to the cause of death? 2 3 Probably 4 Unknown 1 Yaa 2 No signed b Division of Vital Records. à 24b. Were autopsy findings available prior to Be Completed 24a. Was an autopsy performed? completion of cause of death? cardificate 1 ☐ Yas 20 No 1 Yes 2 No Hospital or Attanding Physician: 7 24 hours after death. Funeral Director: After this cartifica stely filled in by the funeral director, p 25. Was case referred to medical axaminer? 26. Place of Deeth (Check only one) Other: 1 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Menner of Death 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Neturel 1 ☐ Yes 2 Accident 3 Suicide 6 Could not be 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 \ Homicide within 24 hours a To the Funeral D completely filled Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. 29e. Certifier \$ 29b. Signature-and titleyof certifie 29d. Dete signed (Month, Day, Year) 2000 21208 30. Name/and address of person who completed cause of death (Item 23a) (Type, Print) GNEEN 11

DHMH 16 Rev 6/95

State Registrar 31. Date filed (Month, Dey, Year)
JAN 1 0 2000

32. Registrer's Signeture

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene AMEND# 4A 10E 1/10/00 CMH AAco Hlth Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** 8:15 AM Sybil S. Cook 2000 January /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 140 Monticello Ave. Anne Arundel Annapolis 8. Dete of Birth (Month, Dey, Year) If Under 24 Hrs. Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Birthplaca (State or Foreign Country) **Funeral** Deys 1 M 2 X F Months 213-48-0192 1905 Director 94 Mass. Usuel Residence of Decedent 10a. Stete 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Directo 288-7 Anne Arundel Annapolis 86 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? b 140 Monticello Ave. 21401 USA Berns 23a Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ₺ No If Yes, Give Year or Dates: 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Bleck, White, etc. 72 hours after 1 Never Merried 2 Merried "natural" or I Saltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: à White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent'a Education (Specify only highest grade completed) filed within 7 Hygiene. other then "n Elementery/Secondary (0-12) College (1-4or 5+) Homemaker Own home permit. Pages 1 and 2 should be filled Department of Health and Mental Hygh Important: If Item 27 is marked other any Injury or other traumatic event, It 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Florence Soule Henry Porter Smith 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Constance C. Schuyler/daughter 205 Providence Rd. Annapolis, MD. 21401 20b. Place of Disposition (Name of cametery, cremetory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete 1 ☐ Burial 2 【☐ Cremation 3 ☐ Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) 1-3-00 Metropolitan Crematory Alexandria, Va. 22. Name and Address of Facility John M. Taylor F.H., Inc. 21. Signeture of Funeral S 147 Duke of Gloucester St. Annapolis, MD.21401 Perf. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart feiture. List only one cause on each line. Approximate Interval Between Onset and Deeth Physician erebrovasculor accident /Medical Immediate Cause (Final disease or condition resulting in death) 3 days Examiner Due to (or as a consequence of) Examine Ayrelenno attending physician and for use as the burial-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medical Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. P.0. signed by the 1 Yas 22 No 3 Probably 4 Unknown Records, à The law requires 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed completion of cause of death? page 2 ...or Vital
...ospital or Attending Physician: Th.
Vin 24 hours after death.
Ne Funeral Director: After this nevership filled in by the "... 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27 Menner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the Hosp within 24 ho To the Fune completely fi (Check only one) 29b. Signeture and title of certified 29c. License number 29d. Dete signed (Month, Day, Year) 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 16 Rev 6/95

State

R. Scott Eden, M.D.

JAN 0 4 2000

31. Date filed (Month, Day, Year)

32. Registrer's Signature

600 Ridgely Ave.

Suite 120

Annapolis, MD, 21401

JAN 0 4 2000 Johnson Ji 4 1 12 14

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State of Maryland / Department of Health and Mental Hygiene 0 2239

| | | | | 01 11110 | ale UI | Death | | R | leg. No. | 0.0 | 600 |
|-----------------------------|---|--|---|--|--------------------------------|--|----------------|---|---|---|---|
| | 1. Decedent'a Nama (First, Middle, L | _ast) | | | | | | 2. Date of Dea Month | | Year | 3. Time of Dea |
| sician edical | Audrey | Mildred | Conway | | | | | January | | | 1010A |
| ner | 4a Facility Name (If not institution, g | iva street and number) | | | | 4b. City, Tov | vn, or Lo | cation of Death | 4c. County | | |
| | 112 Red Toa | d Road | | | | Nor | th 1 | East | Cec | il | |
| | 218-22-8692 | Sex 7. Age 1 M 2 1 F | (In yrs. last birth | Month | der 1 Yaar hs Days | If Under 2 Hours | Min. | 8. Data of Birth (Month, Day April 1, | , Year) | 9. Birthpl Count Mary | |
| | Usual Residence of Decedent 10e. State 10b. County | | 10c. City, Town | or Location | | | | | | 10 | d Inside City Li |
| CIOL | Maryland Cec | i1 | | East | | | | | 10d. Insida City Limita 1 ☐ Yes 2 ☒ No | | |
| al Director | 10e. Street and Number 112 Red Toad Ro | ad | | 10f. | Zip Code 2190 | 1 | | 1 | Og. Citizen of United | | |
| by Funeral | 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced | 1 Never Married 2 Married Armed Forces? 1 Yes 2 No | | | | | | ocify Yas or No- Rican, atc.) | | Rece - American Indian, Black, Whita, atc. | |
| | | 15. Decedent's Education (Specify only highest grade completed) | | | | pation during most | of worki | na | 16b. Kind of B | usiness/Ind | ustry |
| Completed | Elementary/Secondary (0-12) | | | | | d) 'k | | | Reta | il | |
| ŏ | 17. Father's Name (First, Middle, Las | st) | | | | | r's Nama | (First, Middla, I | | | |
| o Re | Charles Moore | | | | | J | Janie | Rothwe | e11 | | |
| | 19a. Informant's Name/Relationship Grace Pursley/Ni | | | | | | | A Routa Number | | | |
| | 20a. Method of Disposition 1X Burial 2 Cremation 3 4 Donation 5 Other (Spec | | 20b. Place of Commentary, | crematory o | or other pla | | m 17 | | 20c. Location | | m, Stata Marylai |
| edical Examiner | Sequentially list conditions, if any, leading to immediate cause. Either Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Che | Oue to (or as a co | nsequence of | notu | ie lu | MS | Inean | e | | mary y |
| Physician/M | Part II. Other significant conditions | d | t not resulting in t | he underlyin | o causa cir | ven in Part I | | 23h Did to | phaceo uan es | entribute to | the cause of de |
| y Phys | | | | | | | | 1 🗆 Y | 'ea 2□No | 3 Prob | ebly 4□Unk |
| | | | | | | | | 24a. Was a perform | n autopsy med? | ava con | ra autopsy lindir ilable prior to apletion of cause leath? |
| pieted t | | 7. | | | | | | | as 2 No | 10 | Yas 2 No |
| Completed b | | | | | | | | 1 🗆 Y | 85 Z 120 NO | | |
| | 25. Was casa referred to medical | | | | | 28. Place | of Deeth | (Check only or | | | |
| To Be | examiner? | | nt 2 ER/Outp | | DON | her: 4 Nu | | | 7a) | ner (Specify |) |
| 10 00 | examiner? 1 | 28a. Data of Injun (Month, Day | Year) 28b. Tir | na of ury M | 28c. Inju Wo | her: 4 Nu | rsing Ho | n (Check only or me 5 Passide 28d. Describe h | ence 6 DOttow injury occur | rred | |
| Certification: To Be | examiner? 1 Yes 2 No 27. Manner of Death 1-Natural 5 Pending investigati 3 Suicide 6 Could not determine | 28a. Place of Injunded description (Month, Day) 28a. Place of Injunded description (Month, Day) 28a. Place of Injunded description (Month, Day) | Year) 28b. Tir Inj ry - At home, fam (Specify) | M n, street, fec | 28c. Inju Wo 1 | ner: 4 Num ry at rk? I Yes 2 1 | No : | me 5 PAeside 28d. Describe h | ence 6 Otto ow injury occur treet and Numin, State) | rred ber or Rura | Route Number, |
| edical Certification: To Be | examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigate 3 Suicide 6 Could not determine 29a. Certifier 1 Certifying P | 28a. Data of Injur (Month, Day) | Year) 28b. Tir Inj ry - At home, fam (Specify) | M , streel, fec | 28c. Inju Wo | ner: 4 Number Number: 4 Number Number: 4 Number Num | No in place, u | me 5 Paside 28d. Describe hi 28f. Location (S City or Town | ence 6 Otto ow injury occur treet and Num. n, State) ause(s) and m | ber or Rura | Route Number, |
| edical Certification: To Be | examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigati 3 Suicide 4 Homicide 29a. Certifier 1 Certifying P (Check only 2 Medical Example) | 28a. Date of Injune be dependent of the best of the be | Year) 28b. Tir Inj ry - At home, fam (Specify) | M M street, fed death occurr or investigat | 28c. Inju Wo | ner: 4 Num ny at nt? 1 Yes 2 1 P | No in place, u | n (Check only or me 5 Paside 28d. Describe h 28f. Location (S City or Town and due to the c ed at the time, d | ence 6 Otto ow injury occur treet and Num. n, State) ause(s) and m | ber or Rural anner as stand due to | Route Number, ated. the cause(s) |
| 2 | examiner? 1 | 28a. Date of Injune be dependent of the best of the be | Year) 28b. Tir Inj ry - At home, fam (Specify) | M M street, fed death occurr or investigat | 28c. Inju Wo 1 tory, office | ner: 4 Num ny at nt? 1 Yes 2 1 P | No in place, u | n (Check only or me 5 Paside 28d. Describe h 28f. Location (S City or Town and due to the c ed at the time, d | ence 6 Otto ow injury occur treet and Num. n, State) ause(s) and m late and plece, | ber or Rural anner as stand due to | Route Number, ated. the cause(s) |

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State of Maryland / Department of Health and Mental Hygiene

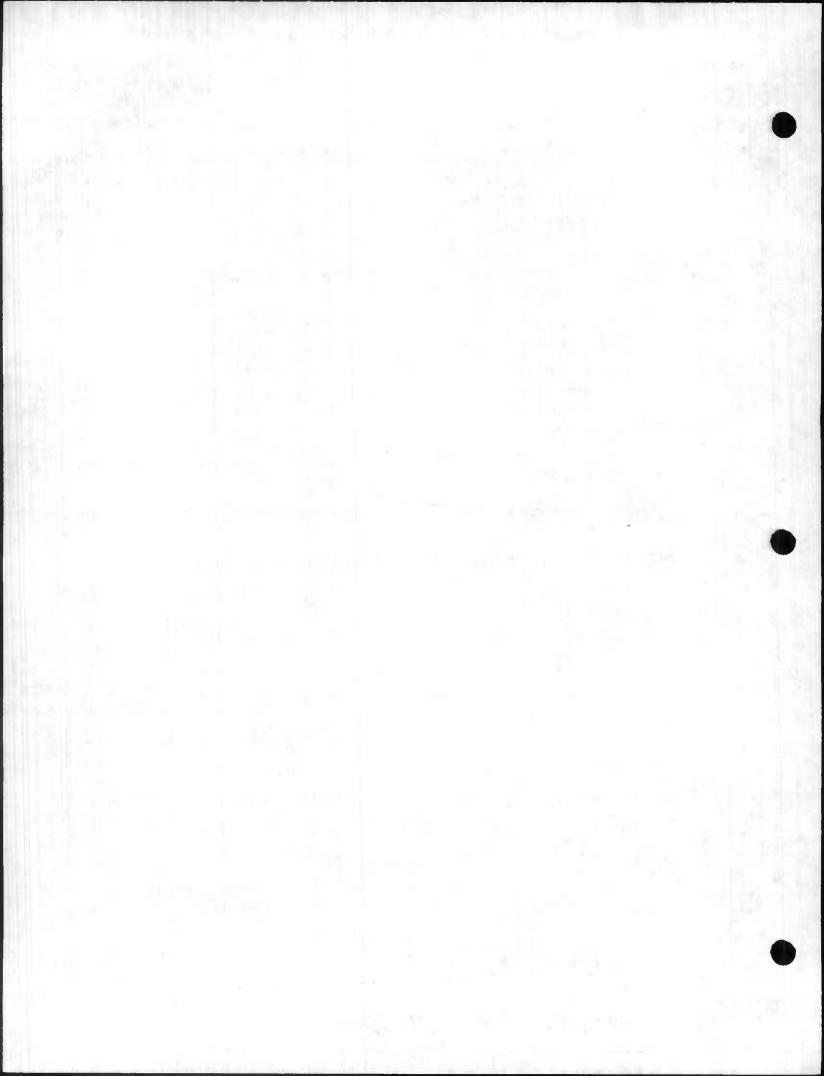
| | | | | | Certificate of | Death | F | Reg. No. | 02240 |
|--|-----|--|--|--|---|---|---|----------------------|--|
| Physician | | Decedent's Nama (First, Middle, La | SHIRLEY M. | DELI | | | 2. Date of Dea Month | Day | 3. Tima of Dea |
| /Medical | ŀ | 4a. Facility Name (If not institution, gi | | ונונוט | | 4h City Town o | JAN. | 14, 20 4c. County | |
| Examiner | | WESTMINSTER NU | | | | WESTMI | | | ROLL |
| Funeral | - | 5. Social Security Number 6. | Sex 7. Age (In | yrs. lest birt | hdey) If Undar 1 Year Months Days | If Under 24 Hr | s. 8. Date of Birti | h | Birthplace (Stata or For Country) |
| Director | | 217-09-7824 Usual Residance of Decedent | 1□ M X OF 9 | U | Yrs. | Flours Mil | 8/22/1 | 909 | MARYLAND |
| or 28a-f show | - 1 | MD. County CARROL | | | or Location | | | | 10d. Inside City Li |
| 23a or 28a-f s | | 10e. Street and Number 510 WILLOW AVE | | | 10f. Zip Code 2115 | 7 | | 10g. Citizen of V | What Country? |
| or items | | 11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Wildowed 4 ☐ Divorced | 12. Was Dacedent Evar Armed Forces? 1 Yes 2 No if Yes, Give Year or Dates: | In U,S. | | as Dacedent of Hispanic Origin? (Sp. Yes, specify Cuban, Maxicen, Puerto | | | e - Americen Indian, ck, White, etc. |
| | | 15. Decedent's E (Specify only highest gr | ducetion | 16a. | Decedent's Usuei Occu (Giva kind of work done life. DO NOT use ratire | pation during most of we | orking | 16b. Kind of Bu | WILLE usiness/Industry |
| ther then "nature out, the Medical." | | Elementary/Secondery (0-12) | College (1-4or 5+) | | SALES CI | | | RETAIL | STORE |
| even even | 3 | 17. Father's Name (First, Middle, Last | OMAS B. MA | NN | | 18. Mother's Na ELS | ame (First, Middle, | Maiden Sumer | ne) |
| 7 is marke traumatic To | | 19a. informant's Neme/Relationship (| Type, Print) | 19b. | Mailing Addrass (Stree | t end Number or F | Rural Route Numbe | r, City or Town, | Stata, Zip Code) |
| other 2 | _ | EVELYN T. ARNO | | 0b. Place of | 7 POPLAR Disposition (Name of | | WESTMIN Date | | MD. 21157 City or Town, Stata |
| In the H | | 1 N Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Special | Removal from State (y) | - | y, cramatory or other ple DENCE CEMI | | | | |
| Important any injury 9008 | 3 | 21. Signature of Funeral Service Lice | 1966 | | 22. Name and Address 254 E. MA | | | | AL HOME , MD. 2115 |
| | + | 23a. Part1. Enter the disease or con shock, or heart failure. List-only | plicetions that caused the | death. Do n | | | | | Approximete interval Betwee |
| Physician and Washington to burial-transit about the burial-transit about the burial-transit about the burial transit and buria | | Immediate Cause (Final disaase or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated avents | b. Due Dua | to (or as a c | onsequence of): onsequence of): onsequence of): | (a-6 (| reci di | nt | |
| 200 | | resulting in death) Last | d | | | | | | |
| otached for use | F | Part II. Other significant conditions of | ontributing to death but not | t resulting in | the underlying ceuse gi | ven In Part I. | 23b. Did to | obacco use cor | ntributa to the cause of de |
| igned by the ettend be detached for us. by Physician/ | | | | | | | 1 U Y | ** 2 No | 3 Probably 4 □ Unk |
| should should | - | | | | | | 24a. Was a perfor | n autopsy med? | 24b. Were sutopsy findir svailable prior to completion of ceuse of death? |
| director, page 2 | | | | | | | 1 □ Y | es 20 No | 1 ☐ Yas 2 ☐ No |
| certificate irector, pag be Co | | 25. Was cese referred to medicel examiner? | Hospital: | | - Ott | | eath (Check only or | | |
| | | 1 ☐ Yes 2 No 7. Manner of Death | 1 ☐ inpatient 28a. Date of Injury (Month, Dey Yea | 2 ER/Out | patient 3L DOA | 4 D Nursing | Home 5 Reside | | |
| r: After re funer atlon | | 1 Natural 5 Pending Invastigation | | ir) in | | rk? Yes 2□No | | | |
| al Director: After the lin by the funeral Certification: | | 3 ☐ Suicide 6 ☐ Could not b determined | 286. Place of Injury - A | 28e. Place of Injury - At homa, farm, street, factory building, etc. (Specify) | | | office 28f. Location (Street and Number or Ru City or Town, Stata) | | |
| To the Funeral Director: After the completely filled in by the funeral Medical Certification: | | 29a. Certifier (Check only one) 1 Certifying Ph | e, and dua to the c urred at the time, d | ause(s) and ma ete and place, a | nner as stated. and dua to tha ceuse(s) | | | | |
| Toth | | 9b. Signature and title of certifier | SAIMD | | 29c. Licens | | 2 | 9d. Data signed | d (Month, Dey, Year) |
| | 3 | 0. Name and address of person who HIGF, Malcol | completed cause of death of DR , } | | minstes | m | 0 2115 | 7 (m | -2000 . PANSURIYA |
| State Registrar | 3 | 1. Dete filed (Month, Dey, Yeer) | 32. Registrer's S | ignature | B. Space | | | | 1 0 |
| .cgistiai | | JAN 182 | UUU Dene | , | D. Space | Kel | | | |

and the second constant

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| | mas Devine 1. Decedent's Name (First, Mi | iddle, Last) | | | | Oortin | 10010 01 | f Death | | 2. Date of D | Reg. No. | | 3. Time of Death | |
|--|--|--|---|--|--|--|--|--|-------------------|---|--|--|--|--|
| ysician | MICHAEL THOMAS DEVINE | | | | | | | | | Month JAN. | Day 13, 20 | Year 000 | 0045 AM | |
| Medical aminer | 4a Facility Name (If not institu | tion, give | street and nur | mber) | 744 | | | 4b. City, Tow | vn, or Lo | cation of Dea | | ty of Deeth | | |
| | ROUTE#90 MI | | | | | | | BERI | | | | RCEST | | |
| eral ector | 5. Social Security Number 222-72-7987 | - 1 | M 20F | 7. Age (In 19 | yrs. last bi | | Under 1 Yee onths Days | | Min. | 8. Date of Bi (Month, D 10-03 | rth ey, Year) -80 | | nplace (State or Foreig untry) ER, DELAWAI | |
| by Funeral Director | Usual Residence of Decedent 10a. Stata 10b. Cour | - | | 100 | . City, Tow | wn or Locatio | on | | | | | | 10d. Inside City Limit | |
| | DELAWARE KEN | T | | DO | OVER | | | | | | | | 1 ☐ Yes 2 N | |
| | 10e. Street and Number | | 31 - 18 | | | 1 | Of. Zip Code | le | | | 10g. Citizen of What Co | | untry? | |
| | | | | | | 1 | 1990 | | | | U.S.A. | . Raca - American Indian, | | |
| | | 11. Maritel Stetus 1 X Never Married 2 Married 1 Ves 2 X No 1 Yes, Give Year or Dates: | | | | | Decedent of s, specify Cu Yes 2 No | Hispanic Origiban, Mexican, Specify: | Puerto | ecity Yes or N Rican, etc.) | Ble | ack, White | e, etc. | |
| | | 15. Decedent's Education (Specify only highest grade completed) | | | | a. Decedent's | s Usual Occu | upation | a l a misi | | 16b. Kind of E | | | |
| r, the Medical | Elementary/Secondary (0-12 | - 1 | College (1 | 1-4or 5+) | - | | | e during most red) | OF WORK | ng | | | | |
| | | to (act) | O AUT | | | UTO ST | TO STRIPING 18. Mother's Nam | | | DEVINE | | - | | |
| rtic aver | 17. Father's Name (First, Middle, Last) | | | | | /T TVTN | vic) | | | | | | | |
| umatic | THOUSE WILDELY | THOMAS WILLIAM DEVINE 19a. Informant's Name/Relationship (Type, Print) | | | | (LIVIN b. Mailing Ad | | | | NNE BU | ber, City or Town | n, State, Z | (LIVING | |
| er tre | THOMAS & KELL | Y DEV | INE | | | | | AD, DO | VER, | DELAW | ARE 1990 | 04 | | |
| 46 | 20e. Method of Disposition | 2 □D | omoval from | State d | Ob. Place of | of Disposition | on (Name of bry or other pl L MEMO | lace) | | Date | 20c. Location | - City or T | Town, State | |
| o Am | 4 Donation 5 Other | | emoval nom | State | HAKU | PARK | L MEMO | KIAL (| 01-1 | 8-2000 | DOVER, | DELA | WARE | |
| N in | 21. Signature of Funeral Servi | displase | 99) | | | | | & SONS | 1 | | | 211/ | 6-9762 | |
| 8 8 | SOLL | 10 | m | | | DIMU | THE TOO | G DOMD | | | | 4114 | 0-3702 | |
| | - Andrews | | | - | desami | 495 | COV | RITCHI | в ит | CHUAY | CEVEDN | A DAD | DV MD | |
| | 23a Part Enter the disease | or compli | cations that c | aused the | death. Do | 495 not enter the | GOV. | RITCHII | E HI | GHWAY, | SEVERN | A PAR | Approximate | |
| cian | 23a Part / Enter the disease inock, or heart failure. L | or compli- list only on | cations that c | aused the ach line. | death. Do | 1495 not enter the | GOV. | RITCHI) ying, such as o | E HI | GHWAY, or respiratory | SEVERN | A PAR | Approximate Interval Between Onset and Deeth | |
| cian lical | Immediate Ceuse (Final | | | | | not enter the | ne mode of dy | ying, such as o | cardiac d | or respiratory | SEVERNA arrest, | A PAR | Approximate Intarval Between | |
| | 0 | | cations that che ceuse on e | tra- | ora | not enter the | hoto | RITCHII ying, such as o | cardiac d | or respiratory | SEVERNA arrest, | A PAR | Approximate Interval Between | |
| lical iner | Immediate Ceuse (Final diseasa or condition resulting in death) | | | tra- | ora | not enter the | hoto | ying, such as o | cardiac d | or respiratory | SEVERNA arrest, | A PAR | Approximate Interval Between | |
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DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene \(\cap \cap 2 \)

| 4, 11 | 1. Decedent's Nama (First, Middle, Last) | | | | | | | 2. Deta of Month | | Death 3. Tim | | 3. Tima of Death | |
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| miner | 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or | | | | | | | or Location of De | ath 4c. Coun | ty of Death | | | |
| | Memoria] | l Hospita | al & Med | ical Ce | enter | | | Cumber | land | All | egany | | |
| | 5. Social Security 212–44–4 | 4838 | 3. Sex 1 2 M 2 □ F | 7. Age (In yrs 55 | s. last birtho | Months | Days | | in. (Month, | Birth Dey, Year) 1945 | - | place (State or Foreig intry) many | |
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| | 10e. Street and No 223 Wood | umber ded Ridge | e Road | | | 10f. Zi | Zip Code 21561 | | | 10g. Citizen of What Country? USA | | | |
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| Important: if item 27 any injury or other tr DDCB. | | 5 Other (Spe | | Co | untry | | | | Jan 15,0 | O David | dsvill | le, PA | |
| | 21. Signature of | Service Lic | 2011500 | 21. Signature of Fundinal Service Licensee 22. Name and Address of Fecility | | | | | | | | | |
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and it was

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Date of Death 3. Time of Death JANUARY 14 2000 **Physician** EARNEST LEE DAVIS 11:40 PM /Medical 4b. City, Town, or Location of Death 4a Facility Nema (If not institution, giva street and number) 4c. County of Death Examiner CUMBERLAND ALLEGANY 503 BEALL STREET If Under 1 Yaar | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) NOV 25 1935 5. Social Security Number 7. Aga (In yrs. last birthday) 9. Birthplaca (State or Foreign **Funeral** Months Days Hours M 2DF MARYLAND Yrs 220-32-4294 64 Director Usuel Residence of Decedent 10a Stete 10c. City, Town or Location 10h County 10d. Inside City Limits must be nothing at NE Yes 2 No Director ALLEGANY MARYLAND CUMBERLAND 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 21502 U.S.A. 503 BEALL STREET Funeral 12. Wes Decedent Evar in U,S. Amed Forces? 12. Was 2 □ No # Yes, Give Year or Detas:1955-1975 14. Race - American Indian, Bleck, White, etc. 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Morital Status 1 ☐ Never Married 2 Merried 1 ☐ Yas 2 No Specify: Specify: WHITE à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast greda completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) Cotlega (1-4or 5+) U.S.ARMY 12 U.S.ARMY 18. Mother's Neme (First, Middle, Maiden Sumama) 17. Fathar's Nama (First, Middla, Last) Be CLYSTA SHAW EARNEST DAVIS 19e. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) ANNA DAVIS WIFE 503 BEALL STREET CUMBERLAND MARYLAND 20e. Method of Disposition 20b. Plece of Disposition (Name of cemetary, cremetory or other plece) Date 20c. Location - City or Town, State = 8 1 ☐ Burlet 2XXX remetion 3 ☐ Removal from Stete Department of Important: If any injury or page. CUMBERLAND CREMATORY JAN 16 2000 CUMBERLAND MARYLAND 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funerel Service Licans 22. Name and Address of Facility MERRITT-ADAMS FUNERAL HOME P.A. 404 DECATUR STREET CUMBERLAND MARYLAND of enter the mode of dying, such as cardiac or respiratory arrest, di. 23e. Part1. Enter the diseese, or comshock, or heert feilure. List only plicetions thet caused the deeth. Do not enter one ceuse on each line. Approximate Intervet Between Onset and Death Immediete Cause (Finel disaese or condition resulting in death) a. Colon cancer 10 months Due to (or as e consequence of) Examiner Sequentially list conditions, if eny, laading to immadiate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or es e consequence of): Physician/Medicai Dua to (or as a consequence of): Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Complications from cancer à 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en autopsy

Physician /Medical **Examiner**

with the Maryland

28a-f ahow

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23a

Rems.

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
int: If Item 27 Is marked other than "natural", or Ne

21215-0020

Baltimore, Maryland

Box 68760.

the burial-tran USB BS page 2 funeral director,

Be Completed

The law requires that the death certificate be executed P.0 á been signed : Records, this certificate Division of Vital Hospital or Attending Physicien: 24 hours after death. After To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A filled in by

ERNEST DAVIS

Medical Certification: To

nus

29a. Certifier (Check only

29b. Signature and title/bl certify

25. Was case referred to medical 1 Yas 2♥ No 28a. Dete of Injury (Month, Dey Year) 27. Manner of Deeth 1 Naturel
2 ☐ Accident 5 Panding investigation 6 ☐ Could not be determined 3 Suicide 4 Homicide

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of

28e. Pleca of Injury - At homa, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Homa 5 Residence 6 Othar (Specify) 28d. Describe how injury occurred 28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

26. Place of Death (Check only one)

150 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar. On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

1 Yes

2(XNo

Janua

1 ☐ Yas 2 ☐ No

12000

16

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR VIK POONAI 920 NATIONAL HIGHWAY LAVALE, MARYLAND

State Registrar

"JAN 1"8 2000 31. Dete filed (Month.

32. Registrer's Signeture

D36766

SAME Some in deal

Physician /Medical Examiner

4a Facility Name (If not institution, give street and number) Memorial Hospital & Medical Center

6. Sex

2. Data of Death Day Month 16, 2000 January

4:30 A.M.

Funeral Director

a or 28a-f ahow

"natural", or items 23a

permit. Pages 1 and 2 should be flied within 72 hours after c Department of Heelth and Mental Hygiene. Important: if item 27 Ia marked other than "natural", or item any injury or other traumatic avent, the Heddal Essentian

Director

Funeral

by

Completed

B

212-24-2339 Usual Residence of Decedent 10b. County

7. Age (In yrs. last birthday) 1 M 2 F 71

Cumberland If Under 1 Year If Under 24 Hrs. Days Months Hours

8. Dete of Birth (Month, Day, Year) DEC 5 1928

Allegany Birthplace (State or Foreign Country) MARYLAND

the Maryland

death

21215-0020

Baltimore, Maryland

Box 68760.

O

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Records,

Vital

jo

Division

212-24-2339

DONAHUE

MARIAN

10a, Stata MARYLAND

ALLEGANY

10c. City. Town or Location CUMBERLAND 10d. Inside City Limits 1 ☐ Yes 2 No

10e. Street and Number

5. Social Security Number

12104 KNOB ROAD N.E.

12. Was Decedent Ever in U,S. Armed Forces? Never Married 2 Married 1 Yes 2 No

21502 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 1 ☐ Yes 2 ☐ No Specify:

10f. Zip Code

U.S.A.

14. Race - American Indian, Black, White, etc. Specify: WHITE

3 ☐ Widowed 4 ☐ Divorced

15. Decedent's Education (Specify only highest grade completed)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

16b. Kind of Business/Industry

Elementary/Secondary (0-12) 12

College (1-4or 5+)

SURGICAL NURSE

10g, Citizen of What Country?

4c. County of Death

17. Father's Name (First, Middle, Last)

NURSE 18. Mother's Name (First, Middle, Maiden Surnama)

FRANCIS NORMAN DONAHUE

19a. Informant's Name/Reletionship (Type, Print)

19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code)

REGINA ANN MARTIN

JUDY DONAHUE

20b. Place of Disposition (Name of cametery, crematory or other place)

SISTER IN LAW 12500 BUCK CROSS LANE NE CUMBERLAND MD 21502 Date 20c. Location - City or Town, State

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

leul

SUNSET CEMETERY JAN 18 2000

CUMBERLAND MARYLAND

Mure of Funeral St We of.

22. Name and Address of Facility MERRITT-ADAMS FUNERAL HOME P.A.

404 DECATUR STREET CUMBERLAND MARLYLAND 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line.

Physician /Medical Examiner

physician and the burial-transit certificate be assecuted

for use as 88

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certificate

this funeral

After

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24 hours efter Funeral Dire letely filled in b 8 Hospital

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Attending

efter death.

To the P within 2 To the I

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Completed

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Certification:

Medical

Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Physician/Medical

Immediate Cause (Final diseasa or condition resulting in death)

a Pancreatic carcinoma

Due to (or as a consequence of):

Liver metastasis

Due to (or as a consequence of)

Due to (or as a consequence of)

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1.

23b. Did tobacco use contribute to the cause of death?

1 Yea 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

24b. Wera autopsy findings available prior to completion of cause of death?

Approximate Interval Between Onset and Death

2 months

months

1 Yes 2 No 26. Place of Deeth (Check only one)

21502

28d. Describe how injury occurred

1 □ Yes 2 □ No

25. Was case referred to medical examiner? 1 Yes 2 No

Hypothyroidism

27. Manner of Deeth 5 Pending invastigation 1 Netural 2 Accident

6 Could not be determined

1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Tima of Injury 28c. Injury at Work?

1 Tyes 2 No

28f. Location (Street and Number or Rural Roule Number, City or Town, State)

29a. Certifie (Check only one)

3 Suicide

4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

In the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

In the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) dical Examiner: On the basis of examiner stated.

29c. License numbe

29b. Signature and title of certifier

D55079

29d. Data signed (Month, Day, Year) ł

hus

State Registrar

47 Virginia Avenue, Paula Waddy, 32. Registrar's Signatur

30. Name and address of person who completed cause of death (Item (3a) (Type, Print)

Hospital:

Cumberland, MD oak

DHMH 16 Rev 6/95

ANT 3 200 James & Sparie

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** January 10, 2000 6:35PM Paul Frederick Dennis /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Prince George's 5341 Southern Ave. Capitol Heights If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) June 12,1916 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplaca (State or Foreign **Funeral** 1 M 2□ F Months Hours North Carolina Yrs 83 Director 239-09-4823 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d Inside City Limits show 1 Yes 2 No Directo 28a-f Maryland Prince George's Capitol Heights 10e Street and Number 10f. Zip Code 10a. Citizen of What Country? "natural", or harms 23a or must be USA 20743 5341 Southern Ave. Funeral 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Giva Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. 1 Nevar Married 2 Married White Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: à 3 ☐ Widowed 4 ☐ Divorced Yaar or Datas: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada completed) permit. Pages 1 and 2 ahoud be filed within Department of Health and Mental Hygiene. Important if Health and Mental department any Injury or other treaments any Injury or other treaments. Elementary/Secondary (0-12) College (1-4or 5+) T.V. Repairman 12th Self-employed 17. Father's Name (First, Middle, Last) 18. Mothar's Name (First, Middle, Maiden Surname) Be Bascom Wade Dennis Flossie Roberson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth Marie Dennis/Wife Same as item 10 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Cemetery 1/14/2000 Brentwood, Maryland 5 ☐ Other (Specify) 22. Nama and Addrass of Facility Funeral Service Licenses George P. Kalas Funeral Home, P.A. 6160 Oxon Hill Rd. Oxon Hill, Md. ales used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, er the disease, or complications that of Approximate Intarval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or Injury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician for use as the buna P.O. Box 68760. Physiclan/Medical eut Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 19/100 2 No 3 Probably 4 Unknown been signed by should be detac Division of Vital Records. p 24b. Ware autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy page 2 1 ☐ Yes 2 🗓 No 1 ☐ Yes 2 ☐ No certificata oapital or Attending Physician: hours after death.

Juneral Director: After this certifically filled in by the funeral director; Be 25. Was case referred to medical 26. Placa of Death (Check only one) Other: 4 Nursing Home AA Residenca 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Tima of 28c. Injury at Work? 1 Matural
2 Accident 5 Pending 1 Yes 2 No Investigation 6 Could not be 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number City or Town, State) 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di completaly filled in 11X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of contilies 29 License number 29d. Date signed (Month, Day, Year) 0 30. Name and address of pers leted cause of death (Item 23a) (Type, Print) Frank Ryan M.D. 701 Livingston Rd. Ft. Washington, Md. 20744 31. Date filed (Month, Day, Year)

JAN 1 2 2000 32. Registrar's Signature State Registrar

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien® Certificate of Death 2. Data of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Physician DENOLA BEAGLE DARGAN ANUARY 08 2000 1450 /Medical 4c. County of Death 4a Facility Name (If not institution, give straet and number) 4b. City, Town, or Location of Death Examiner PHNCE GEORGES PRINCE GEORGES HEVERL HOSPITAL CENTER 7. Aga (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (Stata or Foreign Country) 5. Social Sacurity Number If Undar 24 Hrs. **Funeral** Months Hours 1 M 2 KF Davs 74 241-26-0960 Director 07-31-25 Hungerford, TX Usual Rasidance of Decedant 10c. City. Town or Location 10a Stata 10b County 10d Inside City Limits the Merylen 7 is marked other than "natural", or itama 23s or 28s-f show traumatic event, the Medical Examinat must be not lied at 1 ▼ Yas 2 No Maryland Prince Georges District Heights Directo 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? with 20747 USA 2110 Brooks Drive, Apt. # 201 Funeral death 12. Was Decedant Evar In U,S. Armed Forcas? 1 ☐ Yas 202 No If Yas, Giva Was Decedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, 11. Marital Status Black White etc. filed within 72 hours efter 1 Nevar Marriad 2 Married Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: Specify: Black by 3 ☐ Widowed 4 € Divorced Year or Datas Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Hygiene. Elementary/Secondary (0-12) Collega (1-4or 5+) Dept. of the Navy Clerical Assistant . Peges 1 and 2 should be filed wi ment of Health end Mentel Hygien lant: If item 27 is marked other th jury or other treumatic evant, the 18. Mother's Nama (First, Middla, Maidan Sumame) 17. Fathar's Nama (First, Middla, Last) Be Madge Henderson Stance Beagle 0 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Addrass (Straat and Number or Rural Routa Number, City or Town, State, Zip Code) 8104 High Meadow Ct., Ellicott City, MD 21043 Claude William DarganIII/Son 20b. Placa of Disposition (Nama of camatary, cramatory or other place) 20a. Mathod of Disposition Date 20c. Location - City or Town, Stata 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from Stata permit. Pege Department of Important: If any Injury or pace. Lincoln Memorial Cem. 1-13-00 Suitland, MD 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signatura of Funeral Segrico Ligar 22. Nama and Addrass of Facility Strickland Funeral Services, P.A. 6500 Allentown Rd, Camp Springs, MD 20748 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Batween Onsat and Death **Physician** /Medical Immediata Causa (Final ARTERIOSCUERETTO CARDIOVASCULAR DISEASE disaasa or condition rasulting in daath) **Examiner** Due to (or as a consequence of): Examiner Sequantially list conditions, if any, laading to immadiata cause. Entar Undarlying Cause (Diseasa or injury that initiated avants rasulting in daath) Last pue buriel-tran Dua to (or as a consequence of): deeth certificate be exact Box 68760, physician Physician/Medical the Dua to (or as a consequence of) 98 USB 0 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. signed by the 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records. P 24b. Wara autopsy findings available prior to complation of cause of daath? 24a. Was an autopsy Completed peen The law page 2 hes 2) No 1 ☐ Yas 1 □ Yas 2 □ No certificate Division of Vital Hospital or Attending Physician: 24 hours effer death. Funeral Director: After this certifica director. Be 25. Was case rafarred to medical 26. Place of Death (Check only ona) axaminar? Othar: 4 Nursing Home 5 Rasidanca 8 ☐Othar (Specify) 0 1 Yas 2 No 1 Inpatiant 2 ER/Outpatiant 3 DOA funeral 27. Mannar of Daath 28a. Data of Injury (Month, Day Year) 28d. Dascribe how injury occurred 28c. Injury at Work? Certification: After 1 Natural 2 Accidant 5 Pending Invastigation 1 ☐ Yas 2 ☐ No 3 Suicida 6 Could not be datarmined Location (Streat and Number or Rural Routa Number, City or Town, Stata) 28a. Placa of Injury - At homa, farm, street, factory, office building, etc. (Specify) JA LI 4 T Homicida 24 hours e edical 29a. Cartities 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) To the Hosp within 24 ho To the Fune completely fi 29d. Data signad (Month, Day, Year) 29b. Signature and title of certifie 29c. Licansa number

State Registra MAKLO

GOLLE

31. Data filad (Month. Day, Year)

JAN 1 2 2000 32. Registrar's Signatura

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State of Maryland / Department of Health and Mental Hygiene 0 221, 7

Certificate of Death

| | | | | Certificate | of Death | | Reg. No. | 0 6 6 7 1 | | | |
|---|---|---|-------------------------|---|--|-----------------------------------|-----------------------------------|---|--|--|--|
| • | 1. Decedent's Name (First, Middle, La | st) | | | | 2. Dete of De Month | | 3. Time of Death | | | |
| Physician /Medical | Viola G. Devie | r | | | | Januar | | 00 8:30 pm | | | |
| Examiner | 4e Facility Neme (If not institution, gh | e street and number) | | | 4b. City, Town, or | Location of Death | 4c. County | of Death | | | |
| | Manor Care Nursi | ng Home | | | Silver S | Spring | Montg | omery | | | |
| Funeral | 5. Social Security Number 6. S | | rs. last birti | | ear If Under 24 Hrs | | h Year) | Birthplace (State or Foreign Country) | | | |
| Director | 218-30-2647 | □M 2\\ F 90 |) | rs. | 7,000 | Sept. 2 | , 1909 V | Virginia | | | |
| 9 . | Usuat Residence of Decedent | | A1. T | | | | | | | | |
| show show | 10a. Stete 10b. County | | | or Location | | | | 10d. Inside City Limits 1 Yes 2 No | | | |
| or 28e-1 be notfler | Maryland Montgome | ry B | rooke | | | | | | | | |
| Oire | 10e. Street and Number | | | 10f. Zip Co | | | 10g. Citizen of W | het Country? | | | |
| death with the Maryland res 23s or 28s-f show Linual be notified at neral Director | 400 Greenbridge | Road | | 20833 | | | U.S.A. | | | | |
| | 11. Marital Status | 12. Was Decedent Ever in Armed Forces? | U,S. | 13. Wes Decedent | of Hispanic Origin? (S Cuban, Mexicen, Puer | Specify Yes or Norto Rican, etc.) | - 14. Race Bleck | - American Indian, c, White, etc. | | | |
| 4 × 1 | 1 Never Married 2 Merried | 1 ☐ Yes 2 ☑ No If Yes, Give | | | No Specify: | | Specify: | | | | |
| Era d by | 3 | Year or Detes: | | | 0 -1 | | ороспу. | wnite | | | |
| ad within 72 ho ygisha. Ygisha 4. the Medical. Completed | 15. Decedent's E (Specify only highest on | | 16a. | Decedent's Usuel O (Give kind of work d | ccupation one during most of wo stired) | orking | 16b. Kind of Bu | siness/Industry | | | |
| The state of | Elementery/Secondary (0-12) | College (1-4or 5+) | | | | | | | | | |
| Co Paris | 8 | | Pr | oof Reade | | (**) | | vernment | | | |
| B system | 17. Fether's Name (First, Middle, Last | | | | | me (First, Middle, | | " | | | |
| Men Men To To | George Knicley | | | | | anna Duga | | | | | |
| 2 sh send le m reum | | | | | reet and Number or R | | | | | | |
| and | Betty D. Hancock | | | | idge Road, | | | | | | |
| T SE | 20a. Method of Disposition 1 Burial 2 Cremetion 3 | | o. Plece of cemeters | Disposition (Neme of cremetory or other | plece) | Dete | 20c. Location - I | City or Town, State | | | |
| Pag manual my | 4 Donation 5 Other (Special | y) F | ort L | incoln Ce | metery | 01/12/00 | Brentwo | od, Maryland | | | |
| The Post | 21. Signeture of Funerel Service Lice | nsee | 0 | 22. Name end A | dress of Fecility Funeral F | Jome D / | | | | | |
| STATES | > 71 lanstan | se Haset | | | | | | le, MD 20781 | | | |
| | 23a. Part1. Enter the disease, or com shock, or heart feilure. List only | plications that caused the d | eeth. Do n | | | | | Approximate | | | |
| Physician | snock, or neart reliure. List only | | | Onset and Death | | | | | | | |
| /Medical | Immediete Cause (Finel | | | | | | | | | | |
| Examiner | disease or condition resulting in death) | a Pneumonia | 4 | | | | | 1 Week | | | |
| <u> </u> | Due to (or as a consequence of): | | | | | | | | | | |
| an and rial-transit | | b | lor ac a o | onsequence of): | | | | 1 | | | |
| avec n and isl-tra | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | | | | | | | | | | |
| death certificate be assected estending physician and of for use as the burial-transit iclary/Medical Examir | Cause (Disease or injury that initiated events | C | (010000 | annaurana aft. | | | | | | | |
| tificate be g physicia as the bu | resulting in death) Last | 000 (0 | (or as a co | onsequence of): | | | | 92 TA | | | |
| nding use a | d | | | | | | | | | | |
| v requires that the death cer been signed by the attendir should be detached for use leted by Physician/A | Deall Other standstands and distance | - A 20 A' - A - d - Ab b A - A | | | - character Book I | mar Old |) | Adhiring to the course of death | | | |
| y the checked | Pert II. Other significant conditions of | ontributing to death but not | resulting in | the underlying ceus | given in Part I. | | | tributa to the cause of death | | | |
| ed by the detache | Organic Brain Sy | ndrome | | | | 10 | 1 Yes 2 No 3 Probably 4 | | | | |
| signe d be d | | | | | | 24a Wes | en autopsy | 24b. Were autopsy findings | | | |
| requires | | | | | | perfo | rmed? | 24b. Were autopsy findings available prior to completion of cause | | | |
| nas b e 2 s mpl | | | | | | | | of death? | | | |
| The law requir | | | | | | 10 | Yes 2K No | 1 Yes 2 No | | | |
| shrifting striffic sctor | 25. Wes case referred to medical examiner? | | | | | eth (Check only o | one) | | | | |
| | 1 ☐ Yes 2 ☒ No | | □ ER/Out | | II. | Home 5 Resid | dence 8 Othe | ır (Specity) | | | |
| tending Phiesth. Tor: After thi the funeral cation: 7 | 27. Manner of Death XX Netural 5 ☐ Pending | 28a. Dete of Injury (Month, Day Year | 28b. Ti | me of 28c. | Injury at Work? | 28d. Describe | 28d. Describe how injury occurred | | | | |
| ends besth. best | 2 Accident investigation | | 1 Yes 2 No | | | | | | | | |
| rect rect | 3 Suicide 6 Could not b 4 Homicide determined | 28e. Plece of Injury - A building, etc. (Spi | 28f. Location (3 | 281. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| To the Hospital or Attending Pt within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral Medical Certification: | | | | | | | | | | | |
| he Hospi in 24 hou he Funer pletely fill edical | 29e. Certifier 1∑ Certifying Ph (Check only 2 Medical Exam | On the basis of exam | nowledge, | deeth occurred at the | e time, date end plec | e, end due to the | cause(s) and mai | nner as stated. | | | |
| he Hin 24 | 11/ | and menner steted. | | | | | | | | | |
| To the troop | 29b. Signature and title of cartilled | / | | 29c. Li | cense number | | 29d. Date signed | (Month, Day, Year) | | | |
| | 111/11 | • | - | D25 | 430 | | January | 11, 2000 | | | |
| (12) | 30. Name and address of parameters | completed ceuse of death (| tem 23a) (1 | Type, Print) | | | | | | | |
| | John Margolis, M | | | | e, Laurel, | Marvlan | nd 20707 | | | | |
| State | | | | , , | 16. | , , | | | | | |
| Registrar | 31. Date filed (Month, Day, Year) JAN I 2000 | Seneva | | . door | h | | | | | | |

Please Type or Print in Black Indelible Ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene \(\) Certificate of Death 2. Data of Death 3. Time of Death 1. Decedent's Nama (First, Middle, Last) Day Nonth Year 2 15 PM Dye 06 2000 Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c, County of Death 5. Social Security Number If Undar 24 Hrs. 9. Birthplace (Stata or Foreign Country) est Virginia 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, May 5, Hours 1□M 2□F 1928 216 20 4270 West Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No P.G. District Heights 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 6706 Alpine Street #2 20747 United States 12. Was Decedent Ever in U,S. Armed Forces?

1 Yes 2 (No If Yes, Give Year or Dates: 14. Race - American Indian, Black, Whita, atc. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 11. Marital Status 1 Never Married 2 Married 1 Yas ¾ No Specify: Specify: White 35 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8th Waitress Restaurant 18. Mothar's Nama (First, Middla, Maiden Sumame) 17. Father's Nama (First, Middle, Last) Elmer Ward Nestor Ruby Helen Knipple 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 6706 Alpine Street #2, District Heights, MD 20747 Mary L. Mathers (SISTER) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 Disposition 2 Cremation 3 Disposual from State Data 20c. Location - City or Town, State Cedar Hill Cemetery Jan 10,2000 | Suitland, Maryland 4 Donation , 5 Detror (Specify) 22. Nama and Addrass of Facility Lee Funeral Home, Inc 6633 01d 21. Signature of Funeral Service Licens Mo1095 Alexandria Ferry Road, Clinton, Maryland 20735 23a. Paryl. Enter the disease construction of heart failura. List only icultions hat caused the death. Do not enter tha mode of dying, such as cardiac or respiratory arrest, no cause on each line. Approximate Interval Between Onset and Death Immediata Cause (Final Carrier arrhythm mens disease or condition resulting in death) CAD geons Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 1 Yes 2 No 3 Probably 4 Unknown Presemonia 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yas 2 No 1 Yas 2 AN 25. Was casa referred to medical axaminer? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Rasidence 8 Other (Specify) 1 Yes 2 No #⊞Inpatient 2□ ER/Outpatient 3□ DOA 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28d. Dascribe how injury occurred 28b. Time of 28c. Injury at Work? 1 DNatural 5 Pending investigation 1 Tas 2 No

Examiner physician and the burlei-transit Box 68760. Physician/Medical signed by the attending of the detached for use as P.O. Division of Vital Records. þ Completed paga 2 or Attending Physicien; Be To this funeral Certification: After

Physician /Medical

Examiner

Physician

Medical

Examiner

Director

Funeral

þ

Completed

Be

MD

Funeral

Director

the Maryland

permit. Peges 1 and 2 should be filed within 72 hours effer deeth with the Marylen Department of Health and Mental Hygiena. Important: if itam 27 is marked other than "natural", or hems 23a or 28a-f show suy fujury or other traumatic event, the Medical Examinar must be notified at page.

Baitimore, Maryland 21215-0020

To the Hospital or Attending within 24 hours effer death.
To the Funeral Director: Afti completely filled in by the fun Medical

31. Data filed (Month, Day, Year) State JAN 1 1 2000 Registrar

2 Accident 3 ☐ Suicide

4 | Homicide

(Check only one)

29b. Signature and title of cerofie

29a. Certifier

6 ☐ Could not be

29c. License number 26352

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Data signed (Month, Day, Year) 2000

28f. Location (Street and Number or Rural Routa Number, City or Town, State)

30. Nama and address of person, no completed cause of death (Item 23a) (Type, Print)

OHAYe 9/31 Piscaturary Rel 32. Registrar's Signature

28e. Place of Injury - At homa, larm, street, factory, office building, etc. (Specify)

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

| | | | | Certificate of | f Death | | Reg. No. | 02243 | | | |
|---|--|---|---|---|--|---|-------------------------------------|---|--|--|--|
| Plants in | 1. Decedent's Name (First, Middle, L | asi) | | | | 2. Date of De Month | | 3. Time of Death | | | |
| Physician /Medical | HACKN | | 1, 200 | | | | | | | | |
| Examiner | 4a Facility Neme (If not institution, g | ive street and number) | 4 | | 4b. City, Town, or | Location of Death | 4c. County | of Death | | | |
| | SUBURBAN HOSPI | TAL | | | BETHES | | | GOMERY | | | |
| Funeral Director | 5. Sociel Security Number 6. 578–50–2339 | Sex 7. Age (N 1)X M 2□ F 67 | n yrs. last birt | hday) If Under 1 Ye Months Day | | | | Birthplace (State or Forei Country) North Carolin | | | |
| 2 | Usual Residence of Decedent | 140 | . Oh. T. | | | | | 40444.004 | | | |
| n the Merylan r 28a-f show notified at | D.C. 10b. County | | oc. City, Town Washi | ngton | | | | 10d. Inside City Limi | | | |
| with the Mer a or 28s-f at the notified | 10e. Street and Number | | 217 | 10f. Zip Cod | | | 10g. Citizen of V | | | | |
| s 23a must b | 3322- 14th St | | | 2000 | | nacify Yes or No | U.S | - A - | | | |
| Maryland 21215-0020 d 2 should be filed within 72 hours after death with the Meryland th and Mental Hygiene. The marked other than "natural", or items 23s or 28s-f show traumetic event, the Hedge Essenties must be notified. To Be Completed by Funeral Director | 1 Never Married 2 Merried 3 Widowed 4 Divorced | 1 Never Married 2 Merried Armed Forces? 1 Mayes 2 No li Yes Give | | | of Hispanic Origin? (Suban, Mexican, Puer No Specify: | to Rican, etc.) | | k, White, etc. Black | | | |
| 1 21215-002 ed within 72 hours ygiene, "netural", nor then "netural", it, the Medical Est | 15. Decedent's E | Education | 16a. | Decedent's Usuel Occ | cupetion | dian | 16b. Kind of Bu | siness/Industry | | | |
| Pin 7 | (Specify only highest go Elementary/Secondary (0-12) | College (1-4or 5+) | | (Give kind of work do life. DO NOT use rel | ired) | rking | | | | | |
| 21 Sorth | 12th | | N | ot Availab | ole | | N/A | | | | |
| De file outh | 17. Father's Neme (First, Middle, Las | 1) | | | 18. Mother's Nar | me (First, Middle, | Maiden Sumam | e) | | | |
| yla Went the Ment of the office of the offic | Hackney Di | ckerson, Sr. | | | Dell | ar Ford | | | | | |
| 2 sho | 19e. Informent's Neme/Relationship | (Type, Print) | 19b. | Mailing Address (Stre | et and Number or Re | ural Route Numb | er, City or Town, | State, Zip Code) | | | |
| and 3 | Mamie Dickerso | | | 01- 14th S | | #119 W | lash., D | .c. 20009 | | | |
| Battimore, Maryland 212: permit. Pages 1 and 2 should be filed withit Department of Heelth and Mental Hygiene. Important: if Item 27 is marked other than any Injury or other traumatic event, the H page. To Be Comp | 20a. Method of Disposition 1 Buriel 2 Cremetion 3 4 Donation 5 Other (Special Control of Control o | Themoval nom State | | Disposition (Name of y, crematory or other) dale Park | 1 | Date 1/6/00 | | City or Town, State | | | |
| Balti Bemit. Departm Importa any Inju | 21. Signature of Funerel Service Lice | 741. | - 1 | 22. Name and Add | dress of Facility | l Chapel | . Inc. | | | | |
| 0 | 23a Pert1. Enter the disease, or cor shock, or heart fallure. List only | w. Nack | 01 291. | 814- Ur | shur Stre | et, N.W. | | | | | |
| | shock, or heart failure. List only | y one ceuse on each line. | oeath. Don | ot enter the mode of t | lying, such as cardia | c or respiratory a | rrest, | Approximata Intervat Between Onset end Death | | | |
| Physician // // // // // // // // // // // // // | Immediate Ceuse (Final | | > | | | | | | | | |
| Examiner | disease or condition resulting in death) | a | 1 10 TE | NONO | 1 | | | | | | |
| b) | | Due | market " | consequence of): | | | | | | | |
| n si te | | b | | 8515 | | | | | | | |
| SX 68760, certificate be associated and noting physician and use as the burial-transit and an additional Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Due to (or as a consequence of): | | | | | | | | | | |
| | resulting in death) Last | d | o to (or es a ci | onsequence of): | | | | | | | |
| m = 2 % | | | | | | l ant pla | | | | | |
| P.O. Box sat the death cel d by the attendir etached for use | Part II. Other significant conditions | contributing to death but no | ot resulting in | the underlying cause | given in Part I. | 236. Did | -44 | stribute to the cause of deal | | | |
| S, P | | | | | | 10 | 2440 | ogricoady voolina | | | |
| COrd Cord requir should | | | -11 | | | 24a. Was | an autopsy med? | 24b. Were autopsy finding available prior to completion of cause of death? | | | |
| I Rec | | | | | | 10. | Yes 2/No | 1 ☐ Yes 2 ☑ No | | | |
| Vital Relations The law conflicte has rector, page 2 | 25. Was case referred to medical | | | | 00 81 (8- | | | 10168 200140 | | | |
| VIII VIII O VIII O B O B O B O | examiner? | Hospital: | • 🗆 = = = = = = = = = = = = = = = = = = | | Other | ath (Check only o | | | | | |
| O YSO M ion of Vita ding Physician: h. After this certifica is funeral director, titon: To Be C | 1 ☐ Yes 2 X No 27. Manner of Death | 1,Z-Inpatient | 2 ER/Out | patient 3D DOX | 4 🗆 Nuising F | lome 5 Resi | dence 8 LIOtho how injury occurr | | | | |
| After fune | 1)SNaturel 5 ☐ Pending | 28a. Date of tnjury (Month, Dey Ye | ear) to | | njury at Vork? □ Yes 2 □ No | 200. 00001.00 | non injury cooper. | | | | |
| Division of Division of Division of Black Attending Physics after death. In Director: After this ed in by the funeral di | 2 Accident investigation 3 Suicide 6 Could not determined | be one Diese of leium | M 1 Yes 2 No 28e. Place of Injury - At home, ferm, street, fectory, office | | | | | 281. Location (Street and Number or Rural Route Number, City or Town, Stete) | | | |
| Dio din | - I I I I I I I I I I I I I I I I I I I | bulloning, etc. (c | эрвспу) | | | 0.0, 0. 10. | , 0.0.0, | | | | |
| Hospit Hospit Markety fill feat fill fail | 29a. Certifier (Check only one) Certifying P Medical Exa | hysician: To the best of m miner: On the basis of exa end member steted | amination and | death occurred at the | time, date and place y opinion, death occu | e, and due to the urred at the time, | cause(s) and ma date and piece, | nner as stated. and due to the cause(s) | | | |
| To the vilhin Z To the comple | 29b. Signature and title of certifier | | | 29c. Lice | ense number | | 29d. Date signed | (Month, Day, Year) | | | |
| F3 F 8 | 11111 | Muls | | H | 51289 | ව | 1000 | 112000 | | | |
| (1) | 20 Name and address of | as malated as well at | /ltor- 00-1 " | | 2170 | | Januar | 4 , 2000 | | | |
| (4) | 30. Neme and address of person who | | | | . C | tors W | onuland | 20974 | | | |
| | 31. Date filed (Month, Day, Year) | 32. Registrer's | | ark terra | ce, German | itown, M | arytand | 20074 | | | |
| State Registrar | JAN 1 0 200 | | | 4. bour | 1 | | | | | | |

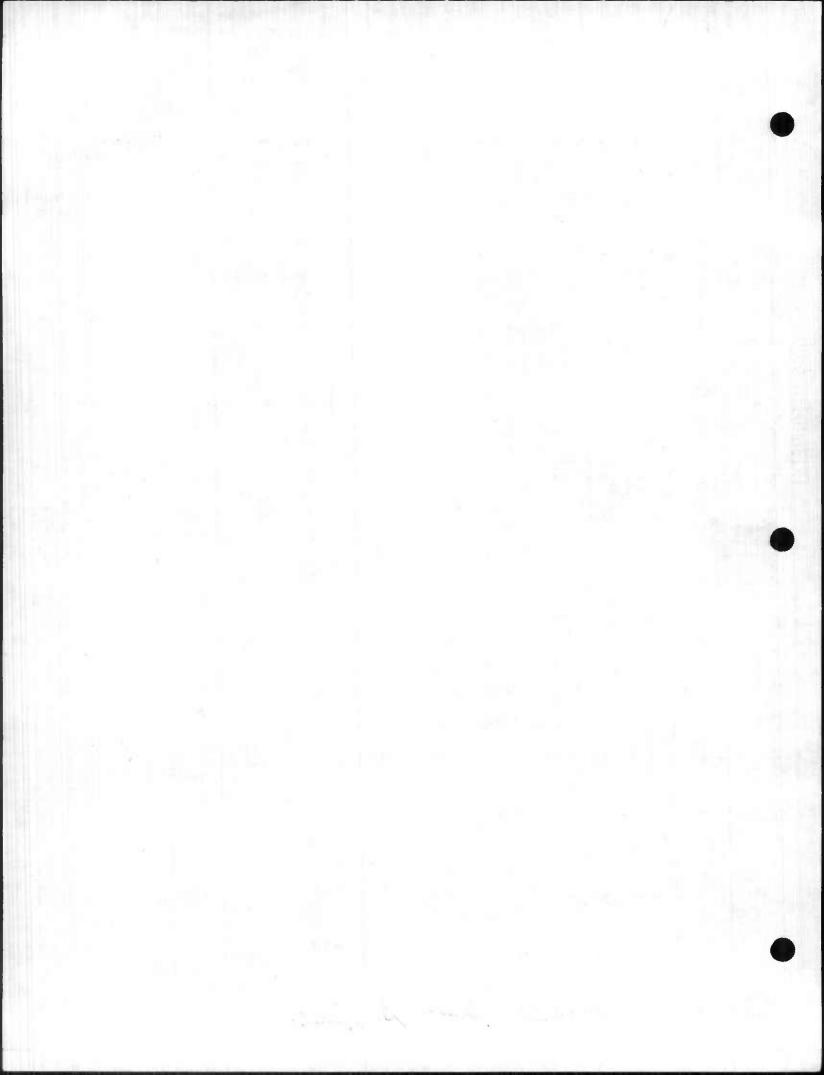
DHMH 16 Rev 6/95

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State of Maryland / Department of Health and Mental Hygiene Amended Item 29c, 1/10/2000 per Carroll County, wjl Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 4:25 A.M. Edith Laverne Dujardin 2000 January /Medical 4a Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Kosadala Baltimore Franklin Square Mospital Center if Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. lest birthday) If Under 1 Year 8. Date of Birth (Month, Dey, Year) Jun 16,1932 9. Birthplece (State or Foreign Country) **Funeral** Days 1 M 3 F Months Hours 212-28-3750 67 Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or froms 23s or 28s-f show other traumetic avent, the Medical Examinar must be notified at Hampstead 1 Yes 2 No Director Maryland Carroll 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Itema 23s or any injury or other traumatic avent. 4400 Sycamore Drive 21074 USA Funeral 12. Wes Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 ☒ No If Yes, Give Yeer or Detes: 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Merital Status Bleck, White, etc. 1 Never Merried 2 Married 1 ☐ Yes 2 ☒ No Specify: White Specify: þ 3 Nidowed 4 Divorced Completed 16a. Decedent's Usuat Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) NUTARDIN, Edith Elementary/Secondary (0-12) College (1-4or 5+) Telephone Co Bookkeeper 12 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle Maiden Sumame) Be John Austin Estella Arnold 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charlene Getz, daughter 309 Barksdale Rd, Joppa, MD 21085 20b. Pleca of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremetion 3 ☐ Removal from Stete Meadowridge Memorial Pk! Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Fecility 21. Signeture of Funeral Service Licensee M00723 Eline Funeral Home 934 South Main St, Hampstead, MD 21074 16 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate fntervel Between Onset end Death **Physician** Carcinoma of /Medical Immediate Cause (Finel Ya Months disease or condition resulting in death) Examine Examiner that the death certificate be executed Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last and Due to (or as e consequence of): physician P.O. Box 68760 Physician/Medical the Due to (or es a consequence of): attending | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? á 1 Yes 2 No 3 Probably 4 Unknown bengis d be det Division of Vital Records, by 24b. Were eutopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy peeu page 2 s 1 Yes 2 No 1 Yes 2 □ No certificate Hospital or Attanding Physician: director, Be 25. Was case referred to medicat examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To this 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28e. Date of Injury (Month, Dey Year) 28c. Injury at Work? After Apital o.
A hours after de.
rei Director: An.
n by the fu 1 Natural 5 Pending 1 Yes 2 No 2 Accident investigation 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide in 24 hour. the Funeral Direction 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 hor To the Fune completely fi fo the 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) ODIOGICO P13631 W 110 100 of deeth (Item 23a) (Type, Print) 19000 Franklin Square Dr. Chane Young 31. Date filed (Month, Day, Year 32. Registrar's Signature State JAN 10 2000 Registrar

DHMH 16 Ray 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1/13/00 AACO Health Certificate of Death AMEND# 1 Per Phy 1. Decedent's Name (First, Middle, Last) 2. Date of Death Câtharine H. DeWeese 3. Time of Deeth Month **Physician** 2000 Н. Delleese 100 Catherine /Medical 4a. Facility Name (If not institution, giva street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner ANNAPULIS 219 King George Street If Under 24 Hrs. 8. Data of Birth
Hours Min. Month, Day, Year If Under 1 Year 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplace (Stata or Foreign Country) **Funeral** Days 1□ M 27 F Yrs. 220-46-3299 Pennsylvania Director Usuat Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Manylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show eny Injury or other traumatic event, the Medical Examines must be notified at 10d. Inside City Limits 1 Yes 2 No Director Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 219 King George Street USA 12. Was Decedant Evar in U,S. Armed Forcas? Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 □ Navar Marriad 2 □ Merried Baitimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: þ 3 Nidowed 4 Divorced White Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent'a Education (Specify only highest grada complated) Elementery/Secondery (0-12) College (1-4or 5+) Homemaker Home 17. Fathar's Nama (First, Middle, Last) 18. Mother'a Name (First, Middle, Maiden Sumama) Mary "Unknown George N. Hillman 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Robert N. Adrian/ Personal Rep. 215 King George Street. Annapolis, Md. 21401 20b. Place of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burlai 2 Cremation 3 Removel from State 4 Donation 5 Other (Specify) Metropolitan Crematory 01-13-00 Alexandria, Virginia 22. Name and Addrass of Facility 21. Signature of Funaral Service Licent John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester Street. Annapolis, Md. 21401 mon 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximate Interval Between Onsat and Death **Physician** /Medical Immediate Cause (Final disease or condition rasulting in death) Examiner sician and burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Disease or Injury that initiated events rasulting In death) Last Dua to (or as a con physician s the burial Division of Vital Records, P.O. Box 68760, Physician/Medical Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1□Yes 2☑No been signed by should be detac 3 Probably 4 ☐ Unknown by 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy performed? 1 ☐ Yas 2 ☐ No Be 25. Was case referred to medical 28. Placa of Deeth (Check only one) Other: 4 Nursing Home Mesidence 8 Other (Specify) 1 Yes 2 No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After 1 Netural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be 3 ☐ Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Piace of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the ceuse(s) and menner es stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. edical 29a. Certifier 29b. Signatura and title of certifian 29c. Licansa number 29d. Data signed (Month, Day, Year) 21438 2000

State Registrar

JAN 1 2 2000

31. Data filed (Month, Day, Year)

Michael LaPenta M.D.

600 Ridgely Avenue Annapolis, Md. 21401 32. Registrer's Signature Timero

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 1. Decedent's Name (First Middle Last) 2. Data of Death January 15, Cecil Calvert Evans 2000 10:10 PM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Dorchester General Hospital Cambridge Dorchester | If Under 1 Yaar | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Aug 29, 1913 5. Social Sacurity Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 XX 2 □ F Yrs. 216-14-2941 86 Maryland Usual Rasidence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 ∑ Yes 2 □ No Maryland Cambridge Dorchester 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 112 Vue de L'Eau Street 21613 12. Was Dacedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Giva Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian, Black, White, etc. 1 ☐ Naver Married 2 ☐ Married 1 ☐ Yas 2 No Specify: White Specify: 3 ₩ Widowed 4 Divorced 15. Dacedant's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT usa ratired) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) Collaga (1-4or 5+) Mariner/Businessman Marine Trasportation 10 17. Fathar's Name (First, Middle, Last) 18. Mother's Name (First, Middla, Maiden Sumame) Raymond Evans Ethel Mary Slacum 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) J. Calvert Evans P.O. Box 248 Vienna, Maryland 21869 20b. Piace of Disposition (Nama of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dorchester Memorial Park 1/19/2000 Cambridge, Maryland 21. Signatur of Funeral Service Licensee 22. Nama and Address of Facility Thomas Funeral Home, P.A. 700 Locust Street Cambridge, Maryland 21613 23a. Per Enter the diseasa, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory are shown or heart failure. List only one cause on each line. Approximate Intervel Batween Onset and Death Immediate Cause (Final disease or condition resulting in death) gesti-Sequentially list conditions, if eny, leading to Immadiata ceuse. Enter Underlying Ceuse (Disaasa or injury that initiated events resulting in death) Last Dua to (or as a consequence ot): myoca DVENDELL Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of ceusa of death? 24a. Was an autopsy performed? 25. Was casa raferred to medical 26. Place of Death (Check only ona) examiner? 20 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Daath 28b. Time of 28d. Dascribe how injury occurred 28c. Injury at Work? 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicida

Box 68760 P.O. Records, Division of Vital

The law requires that the death certificate be executed and the 5 signed be del paga 2 certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica compietely filled in by the funeral director; to

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Physician/Medical

Completed by

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Certification:

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Examiner

Funeral

Director

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Baltimore, Maryland 21215-0020

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Department of Hearth as Important: If them 27 is any injury or other trau

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29a. Certifian (Check only one) 29b. Signature and title of certifian

31. Date filed (Month, Day, Year)

1 Certifying Physician: To the best of my knowledga, daath occurred et the time, date and place, and due to the causa(s) and manner as etated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date end place, and due to the ceusa(s) and manner stated.

JAN 18 2000

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29c. Licanse number 0050987 29d. Date signed (Month, Day, Year) Jan. 17, 2000

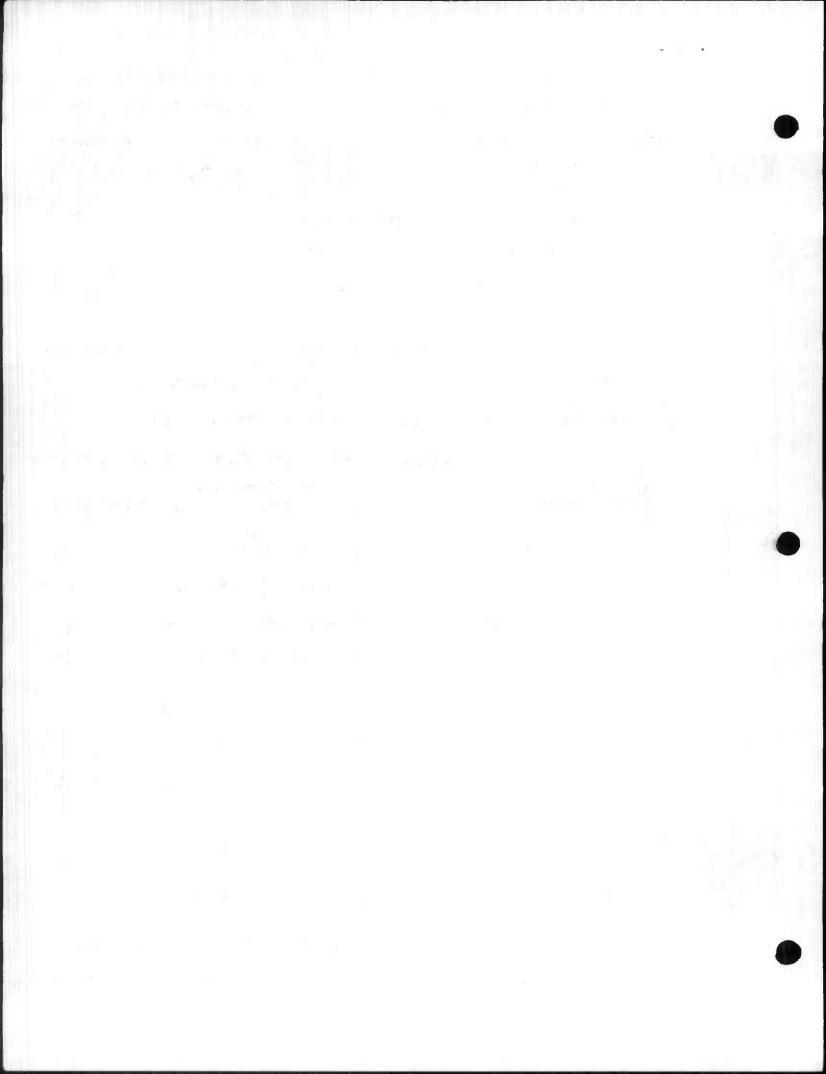
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30. Nama and eddress of person who completed ceuse of deeth (Item 23a) (Type, Print)

Nawa? Ahmed 300 Aurora

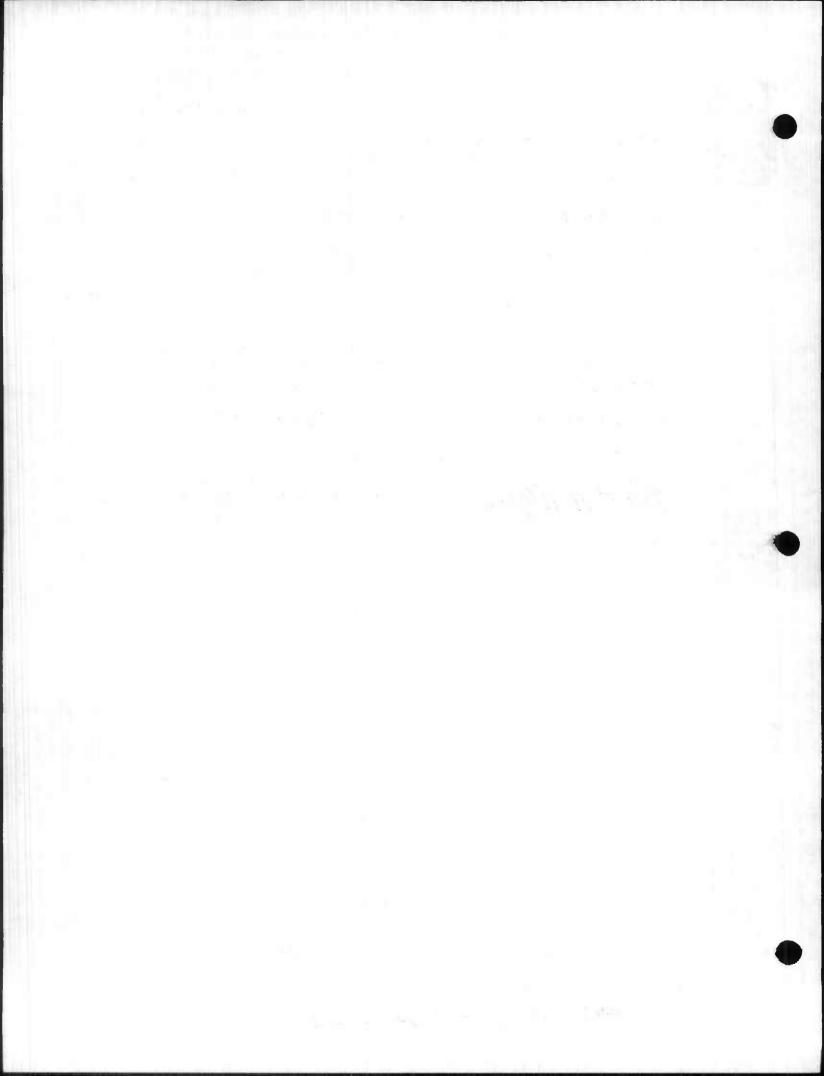
32. Registrar's Signature

State Registrar

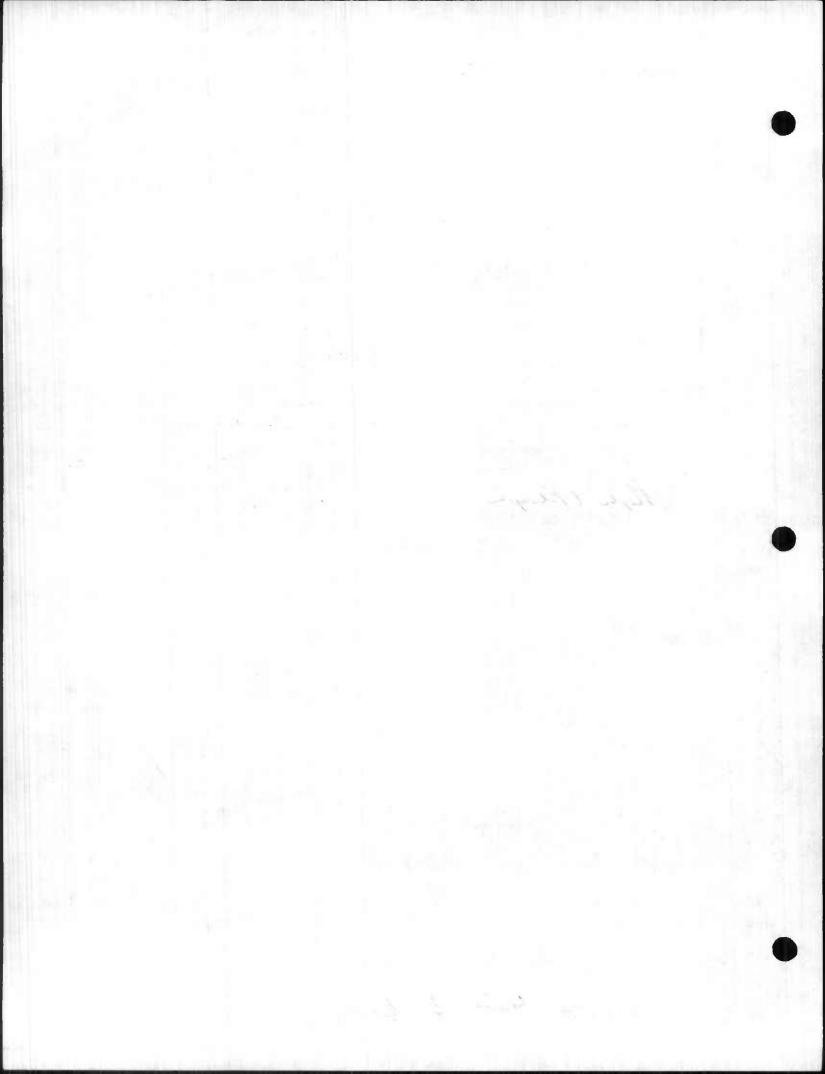


State of Maryland / Department of Health and Mental Hygiene 00

| ## CARROLL COUNTY SENERAL HOSPITAL Particular Directors | | | | 15 | 150 | | , | | | | Death | | Reg. No. | U U | 66 | 53 |
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| Physician Medical Examiner Physician Medical Examiner Physician Medic | Balt | permit. Departminporta | | 21. Signeture of Fu | neral Service Licens | Mines |) | 22 | . Name and | d Addre | ess of Fecility | 91 WILLI | S STREE | T | | |
| Physician Medical Examiner M | | | | 23a. Part1. Enter ti | ne diseese, or comp | olications that caus | sed the deat | h. Do not ente | er the mode | e of dyi | ng, such es cerdie | | | | Approxim | iete |
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| State Stat | 0 | ng Ph ther th meral | | Brand . | | 28e. Dete of I | njury De <i>y Year)</i> | | 28 | Bc. Inju Wo | ry et rk? | 28d. Describe l | now injury occur | red | | |
| 28e. Place of Injury - At home, ferm, street, factory, office 28f. Location (Straet and Number or Rural Route Number, City or Town, Stete) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature end title of certifier 29b. Signature end title of certifier 29c. License number 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) 31. Date filled (Month, Day, Year) 32. Registrer's Signature | Sio | eath. or: Al | catio | 2 Accident | investigation | | | | | | | | | | | |
| 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature end title of certifier 29c. License number 29c. License number 29d. Date signed (Month, Dey, Year) 30. Neme and address of person who completed cause of deeth (Item 23e) (Type, Print) 30. Neme and address of person who completed cause of deeth (Item 23e) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrer's Signature | DIV | rs after d al Direct led in by | Certifi | | determined | 286. Piece of | Injury - At he etc. (Specif | ome, ferm, stre | et, factory, | , office | | | | ber or Rura | Route Nu | imber, |
| 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 29d. Date signed (Month, Dey, Year) 29d. Date signed (Month, Dey, Year) 30. Neme and address of person who completed cause of deeth (Item 23e) (Type, Print) 30. Neme and address of person who completed cause of deeth (Item 23e) (Type, Print) 30. Neme and address of person who completed cause of deeth (Item 23e) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrer's Signature 33. Registrer's Signature | | Hospi 24 hou Funer letely fil | dicai | (Check only | 1⊠ Certifying Phy 2□ Medical Exam | Iner: On the besis | of exemine | wledge, deeth tion end/or Inv | occurred e estigation, | in my | me, dete end piec opinion, deeth occ | e, end due to the urred et the time, | ceuse(s) end modete and piece, | enner es sta and due to | ated. the couse | ∍(s) |
| Fish Fim, M.D. 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) Dr. LISA Kim, M.D. at Carroll county General Hospital at 200 memorial Avenue, Westminster, MD 21157 State 31. Date filed (Month, Day, Year) 32. Register's Signature | | within To the | 2 | 29b. Signature end | title of certifier | | | | 29c. | . Licens | se number | | 29d. Date signe | d (Month, L | Dey, Year) |) |
| 30. Neme and address of person who completed cause of deeth (Item 23e) (Type, Print) Dr. LISA Kim, M.D. at Carroll county General Hospital at 200 mein orial Avenue, Westminster, MD 21157 State 31. Date filed (Month, Day, Year) 32. Registrer's Signature | | | |) X: | m Kin | n M | , D | | 1 | 5 | 2470 | | Janua | RV. | 11 | 0 0 3 |
| General Hospital at 200 meinorial Avenue, Westminster, MD 2/157 State 31. Date filed (Month, Day, Year) 32. Registrer's Signature | | | | 30. Neme and addre | ess of person who c | ompleted cause o | f deeth (Item | 1 23e) (Type, I | Print) A | e 1 | ISA Kim | MA | of Car | roll | 7 1 0 | X000_ |
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| Registrar JAN 4 2000 Value (1) | | | te | 31. Date filed (Mont | h, Day, Year) | 32. Regi | strer's Signa | ture | | , | | | | | 1 | |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amended 1-27-00 AS 1. Decedent's Name (First, Middle, Last) Kathryn 2. Date of Death 3. Time of Death Month Year **Physician** Sara Katherine Edwards January 21 2000 0535 /Medical 4a Facility Nama (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner The Memorial Hospital Easton Talbot If Under 1 Yaar | If Under 24 Hrs 5. Social Sacurity Number 7. Age (In yrs. lest birthdey) 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1□M 20 F Yrs Director 50 March 26,1949 Delaware 56 2095 Usual Residence of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits show 1 ¥ Yes 2 □ No must be notified Director 288-1 Maryland Caroline Greensboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? b Berrs 23s Funeral 21639 101 Vaughn Ave USA 14. Race - Amarican Indian, Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Nevar Married 2 ☐ Married Maryland 21215-0020 'natural', or white 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify: Specify: by 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. other than Elementary/Secondery (0-12) College (1-4or 5+) 12 Nursing aide domestic Edwards 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) h and Mental F 7 is marked of Be 8 Pages 1 and 2 should Joseph O Edwards Iva Hess 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Important: If Item 27 is any injury or other tra-once. 121 Downes Dr Hartley, Delaware 19953 Shane Shulties/ son Baltimore, Sara 20b. Placa of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Mathod of Disposition Date 8 Jan 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21,2000 Chester, Maryland Chesapeake Crematory 21. Signeture of Funeral Service Licenses 22. Name and Address of Facility Fleegle & Helfenbein Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory arrest, shock, or heart failure. List only one cause on each line. 21639 Approximate Intervat Between Onset and Death **Physician** 2405 Ovarian Cacusana /Medical Immediata Cause (Final disaasa or condition resulting in death) Examiner Dua to (or as a consequenca of) Examiner the death certificate be executed physician and the burial-tran Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or Injury that initiated events Due to (or as a consequence of): Box 68760 Physician/Medical that initiated events resulting in death) Last Due to (or as a consequence of) 88 030 o signed by the a d be detached f 23b. Did tobacco use contribute to the cause of death? P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown by Records. The law requires 24b. Were autopsy findings svailable prior to completion of cause of death? should 24a. Was an autopsy performed? Completed page 2 s 1 🗆 Yes 2 1 No 1 ☐ Yes 2 ☐ No Division of Vital 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatiant 2 ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1□ Yes 2□ No this funeral 28a. Data of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After 5 Pending investigation or Attending r death. 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after deal Funeral Director: 6 Could not be determined 3 ☐ Suicide 281. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and plece, end due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end placa, and due to the cause(s) and manner stated. edical 29a. Certifier To the Hosp within 24 ho To the Fune completely fi (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of perifier 2 D 0 30. Nama and address of person who completed cause of death (Item 23a) (Type, Print) 29466 Pintail Dr Suite 5 Easton, Maryland 21601 David H Smith MD 32. Registrar's Signatura 31. Date filed (Month, Dey, Year) State JAN 2 1 2000 Registrar



State of Maryland / Department of Health and Mental Hygiene 00 02255

| | | | C | ertificat | e of | Death | | R | eg. No. | | - Las C/ O |
|--|---|--|------------------------------------|---|---------------------|-----------------------|-----------------------|----------------------------------|-------------------|------------|---|
| | 1. Decedent's Name (First, Middle, Le | est) | | 2,00 | | | | 2. Date of Deat Month | | Year | 3. Time of Death |
| Physician | DOIGOIII | | ESWORT | -IY | | | | | 10, 20 | 000 | 9:45 AM |
| /Medical Examiner | An Paultin, blama of the and bankle dam of | ve street end number) | | | | 4b. City, To | | ocation of Deeth | 4c. County | of Death | |
| Examiner | Frederick Memori | ial Hospita | 1 | | | Fred | eric | k | Fre | deri | ck |
| Funeral | | A | (In yrs. last birtho | (ay) If Under | | If Under | 24 Hrs. | 8. Date of Birth (Month, Day) | | | place (State or Foreign htry) |
| Director | 217-12-2884 Usual Residence of Decedent | 1□ M 2ŒF | 79 Yrs | Months . | Days | Hours | Min. | Sept. 28 | ,1920 | | yland |
| And Mand | 10a. State 10b. County | | 10c. City, Town o | r Location | | | | | | 1 | Od. Inside City Limits |
| or 28a-1 sh be notified. | MD Frederic | ck | Adamsto | | | | | | | | 1 ☐ Yes 2 ☐ No |
| | | wn Pike | | 10f. Zip | 1710 |) | Ğ | | U.S.A. | | ntry? |
| af, or h Examps | 3 ☐ Widowed 4 ☐ Divorced | 12. Was Decedent E Armed Forces? 1 Tyes 2 N ti Yes, Give Year or Dates: | | 13. Was Dece If Yes, spe- 1 ☐ Yes | | | gin? (Spi , Puerto | ecify Yes or No- Rican, etc.) | | ck, White, | |
| ad within 72 ho ygiene. eer then 'natur it, the Medical. Completed | 15. Decedent's E (Specify only highest gr | | 16a. De | ecedent's Usua live kind of wo le. DO NOT u | al Occup rk done | pation during most | of work | ing | 16b. Kind of B | usiness/In | dustry |
| the M | Elementary/Secondary (0-12) | College (1-4or 5 | +) | emaker | 30 701110 | | | | own ho | mo | |
| | | 1) | TIOII | emaker | | 18. Mothe | r's Name | e (First, Middle, I | | | |
| Alental Phase design of the season of the se | D IIDC C. | | | | | | | ladys K | | , | |
| of the same | 19a. Informant's Name/Relationship | (Type, Print) | 19b. N | lailing Address | (Stree | and Numbe | or Aur | al Route Number | City or Town, | State, Zip | Code) |
| and 2 with a v 27 is er tra | Alton D. Esworth | ny, Sr h | usb. 25 | 53A Bu | ckey | stown | Pik | e, Adams | stown, | MD : | 21710 |
| of the other | 20a. Method of Disposition | | 20b. Piaca of D | isposition (Nar crematory or c | ne of | (ce) | 1 | Date | 20c. Location | City or To | own, State |
| Page ment of ant: If ury or | 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Control of Cont | | Locust (| | | | 1, | /13/00 | nr. Mt | . Air | y, MD |
| Depart Import eny in | 21. Signature of Funeral Service Lice | L RANY | MI | 22. Name ar | | | На | rtzler l | | | е |
| - | 23a. Part1. Enter the disease, or com shock, or heart failure. List only | plications that caused | the death. Do not | | | | | | | 110 | Approximate Interval Between |
| /Medical Examiner | Immediate Cause (Final disease or condition resulting in death) | a. aus | Ty My Due to (or as a of | AST (a): | d | id o | the | lente | a | | 1 km |
| certificate be executed uning physicien and use as the burial-transit uninection. | | c | Due to (or as a cor | | | | | | | 1 | |
| N Bing | resulting in death) Last | d | Due to (or as a con | sequence or): | | | | | | | |
| death ce | Part II. Other significant conditions | contributing to death by | it not resulting in th | e underlying o | ausa di | ven in Part I | | 23b Did to | phaceo usa en | ntribute t | o the cause of death |
| hat the death ced by the attend deteched for us | | contributing to death of | it not resoning in t | ie underlying c | ause gi | von mr ant i | | | 2 2 No | | bably 4 Unknow |
| The law requires that the sate has been signed by the page 2 should be deteched on the page 2 should by Physical Physica | | | | | | | | 24a. Was a perfor | n autopsy med? | SV CC | ere autopsy findings railable prior to empletion of cause death? |
| The lay page 2 | | | | | | | | 1 U Y | 9\$ 25No | 1 (| ☐ Yes 2☐ No |
| certificate rector, pag | | | | | | 26. Place | of Deat | h (Check only or | 16) | - | |
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| ding Phys h. After this funeral d | | 28a. Date of Injur (Month, Day | v 28b. Tim | | 28c. Inju | | | 28d. Describe h | | | ,, |
| r Attenter ter deat rector: n by the | 2 Accident Investigation 3 Suicide 6 Could not to 4 Homicide determined | OB Place of lair | rry - At home, farm . (Specify) | | | | | 28f. Location (S City or Town | | ber or Run | al Route Number, |
| Hospit 24 hours Funer (sely fill | | nysician: To the best of miner: On the basis of and manner sta | examination and/o | | | | | | | | |
| within 2 to the comple | 29b. Signature end title of certifier | | - 1 | 29 | c. Licen | se number | 2 | 2 | 9d. Date signe | ed (Month, | Day, Year) |
| F \$ F 8 | Ann 5 | Ce. | els 1 | mp 1 | 03 | 649 | 56 | | 1/11 | /2 | 000 |
| | 30. Nama end eddress of person who | completed cause of de | eath (Item 23a) (Ty | rpe, Print) | , 1 | w a | +1 | 17. 1 | 2/ | 1 | mlum |
| | 31. Date filed (Month, Day, Year) | Seeller 30 Panister | r's Signature | 300 | V | 0171 | h | 1 | ener | 1016 | 11ch 61/01 |
| State | IAN 1 9 2 | | i s signature | 4 | 1 | | | | | | |

1211 2 man from the superior

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Dete of Death 1. Decedent's Neme (First, Middle, Last) ELLIOT 0944A.M **Physician** t N and aret /Medical Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner ANNAPOUS WNE If Under 1 Year | Months | Days If Under 24 Hrs. Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) **Funeral** 1□ M 2□ F 212-42-2460 Director 1, 1910 Maryland Nov. Usual Residence of Decedent the Maryland 10a State 10b County 10c. City. Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show solded Examiner must be notified at 1 Ves 2 No Director Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1004 Poplar Avenue 21401 USA Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yas 2 ☑ No If Yes, Give Yeer or Detes: Wes Decedent of Hispanic Origin? (Specify Yas or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritel Status 14. Reca - American Indian, Bieck, White, etc. filed within 72 hours after 1 ☐ Never Merried 2 ☐ Merried Baitimore, Maryland 21215-0020 1 Yes 2 No Specify Specify: White 2 Q 3 Widowed 4 Divorced Hygiene. other than "nature ent, the Medical Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Pages 1 and 2 should be fill ment of Health and Mental Hy ant; if item 27 is marked oth lury or other treumatic every William M. Owings Leicy J. Simmons 19e. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gary S. Elliott 1004 Poplar Ave., Annapolis, Md. 21401 20a. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 01 Date1 - 0 00c. Location - City or Town, State 1 Burial 2 Cremetion 3 Removal from Stata 4 Donetion 5 Other (Specify) permit. Page Department of Important: If eny Injury or phos. Metropolitan Crematory Alexandria, VA 22. Name end Address of Fecility 21. Signeture of Funerei Service License Beall Funeral Home Robert G. Beall M00025 6512 N.W. Crain Hwy., Bowie, Md. 20715 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximate fnterval Between Onset and Deeth **Physician** /Medical Immedieta Cause (Finel disease or condition resulting in death) 30 m Examiner Physician/Medical Examiner CAD bunal-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) pug +TW Box 68760. physician the thet initieted events resulting in death) Last Due to (of es a consequence of) for use 23b. Did tobacco use contribute to the cause of death? P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yea 2 No 3 Probably 4 Unknown of Vital Records, Completed by 24b. Were autopsy findings available prior to 24a. Wes an eutopsy parlomed? completion of cause of death? 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) 1 Yes 2 No Hospitel: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 □ DOA After this uneral 27 Manner of Death 28d. Describe how injury occurred 28a. Dete of Injury (Month, Day Year) 28c. Injury at Work? Division 5 Pending investigation 1 Netural 2 Accident 1 Yes 2 No 24 hours after death. the f 6 Could not be 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) Pteca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner steted. 29a. Cartifier edical completely (Check only one) within 2 5 20b. Signature end title of certiffe 29c. License number 29d. Dete signed (Month, Day, Year) person who completed dause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year)

JAN 1 1 2000 32. Registrar's Signeture State Registrar

DHMH 16 Rev 6/95

| | 1 | I Decedent's Nom | ie (First, Middle, La | etl | | | illicate t | of Death | - | 2. Dete of Dec | Reg. No. | | 3. Time of Death |
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| ritema finerim | 5 | | ied 2 Married | Armed Force | es? XNo | | If Yes, specify (| Cuban, Maxican, | Puerto P | licen, etc.) | | ack, White | e, etc. |
| P. Person | à | Widowed | | If Yes, Give Year or Dete | | | 1□ Yes XX | No Specify: | | | Speci | ity: Wi | nite |
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| to be | 000 | | (First, Middle, Last, | | | | | 16. Mother | | | Maiden Suma | iiia) | |
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State Registrar 30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print)

P. W. SOTSKY M. D. 12070 OLD

31. Dete filed (Month, Day, Year)

JAN 1 1 2000 32. Registrer's Signature

Language Age

12. April 1

State of Maryland / Department of Health and Mental Hygiene \(\cap \) Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Tima of Death Month **Physician** 2:50 AM VANWARY OLGA V. FONVILLE /Medical 4c. County of Deeth 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) Examiner Lanham
If Under 24 Hrs. | 8. Date of Birth
Hours | Min. (Month, Dey, Year) Doctor's Hospital Prince George's 5. Social Security Number If Under 1 Yeer 6. Sex 7. Age (In vrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 1 M 20 F 85 Months Days Director Nov. 23, 1914 155-03-2195 Maryland Usual Residence of Decede 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Prince George's 1 XYes 2 No Maryland Lanham. Director 280-1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? b 10307 Halton Terrace 20706 United States Nerns 23s 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ XNo If Yes, Give Year or Detes: 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11 Marital Status Bieck, White, etc. 1 ☐ Never Merried 2 ☐ Merried 'natural', or 1 Yes 2 No Specify: Specify: Black ğ 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Collegey(1-4or 5+) Elementary/Secondary (0-12) Statistician Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Pages 1 and 2 should be next of Health and Mental Mabelle Johnson Ernest Vrooman 19a. Informent's Name/Relationship (Type, Print) 19b. Meiting Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Department of Health a important: If Item 27 Is any injury or other tra once. Mischelle Johnson - Daughter 10307 Halton Terrace, Lanham, MD 20a. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel Irom State 4 ☐ Donation 5 ☐ Other (Specify) Arlington National Cem. 1/19/2000 Arlington, VA 21. Signature of Funeral Service Licensee 22. Name end Address of Fecility Stewart Funeral Home 4001 Benning Rd., N.E. Wash., D.C. 20019 WM 23a. Part Enter the disease, or complications that baused the deeth. Do not enter the mode of dying, such as cardiec or respiretory errest, shock or heart feiture. List only one cause on each line. Approximate tntervel Between Onset and Death **Physician** /Medical immediete Causa (Final disease or condition resulting in death) Examiner Due to (or as a consequence of): Examine EHYDRATION iclan and burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): GASTROENTERITIS physician as the burial Physician/Medical Due to (or es a consequence of) USe Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert 1. 23b. Did tobacco use contributa to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown The law requires thet DEMENTIP Records, þ 24b. Ware autopsy lindings available prior to completion of cause of death? Completed 24a. Wes an autopsy performed? page 2 s 108 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical axaminer? Be 26. Place of Deeth (Check only one) To Hospitel: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred Certification: 28c. Injury et Work? After Netural 5 Pending investigation or Attending death. 1 Yes 2 No 2 Accident n 24 hours ster death.

Se Funeral Director: A pletely filled in by the f 3 ☐ Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, Ierm, street, lectory, office building, etc. (Specify) 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated.

2 Intedical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and menner steted. 29e. Certifier edical To the Hosp within 24 ho To the Fune completely fi (Check only one) 29b. Signeture and title of curtify 29c. License number 29d. Dete signed (Month, Dey, Year) 15558 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PERRY STREET, MT. RAIDIER MD SUKUMARAD ARVANGAT MD

32. Registrer's Signeture 31. Date filed (Month, Day, Year)
JAN 1 3 2000

State Registrar

DHMH 16 Rev 6/95

Box 68760.

P.O.

Division of Vital

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Per Phys. PGC 1-14-2000 cr 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Year SARAH FORTE OTPIN 2000 JAN 4e. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Prince, George's OF HIM TTSVILLE HEARTLAND HEALTHCARE Hyattsville 5. Sociel Security Number 226-22-3531 If Under 1 Year Months Days 6 Sex 7. Age (In yrs. last birthday) if Under 24 Hrs Birthpiace (State or Foreign Country) 1□M 212F MARCH, 16, 191 NORTH Usual Residence of Decedent 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits 117 Yes 2 □ No Prince George's Hyattsville 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 5512 Randolph Street 20784 USA 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Biack, White, etc. 1 □ Never Married 2 □ Married 1 Yes 2 No Specify: Black. If Yes, Give Year or Dates: 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Domestic N/A 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) Johnny Strickland Mattie Exum 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Delena Benjamin/Granddaughter 16503 Bauer Court Upper Marlboro, MD 20772 20b. Piace of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, State 1 Buriel 2 ☐ Cremation 3 ☐ Removal from Stete 1/15/2000 Maryland National Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Laurel, MD 22. Name end Address of Facility Tyrone J. Young Funeral Services 719 Kennedy Street, NW Wash., DC ron 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Ceuse (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last as a consequence of): 23b. Did tobacco use contribute to the cause of death? 1 Yes ZONO 3 □ Probably 4 □ Unknown

Physician /Medical Examiner

Amend # 4c

Physician

/Medical

Examiner

Funeral

Director

28a-f ahow

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items 2

natural, or

Il Hygiene.

is marked other

Peges 1 and 2 should be nent of Heelth and Mental nt: If item 27 is marked o

permit. Peges 1 end Department of Heelth Important: If them 27 eny injury or other tr once.

hours after

Baltimore, Maryland 21215-0020

the Medical Examiner must be notified at

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Physician/Medical

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Medical

buriel-transit the esn for ned by 8 been pege 2 certificate director. 10 this funeral Certification: After deeth. i or Attend efter deeth Director: /

The law requires that the death certificate be execu

P.O. Box 68760.

Division of Vital Records,

Attending Physician:

Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 24a. Was an autopsy performed? 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1□Yes 2□No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 45 5 ☐ Residence 6 ☐Other (Specify) 27 Mariner of Death SNatural 5 ☐ Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, building, etc. (Specify) fastory, office 4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and menner stated. License numbe 29d. Dete signed (Month, Day, Year)

State

Registrar's Signature 32.

person who completed ceuse of death (Item 28a) (Type, Print)

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

ber or Rural Route Number,

Registrar

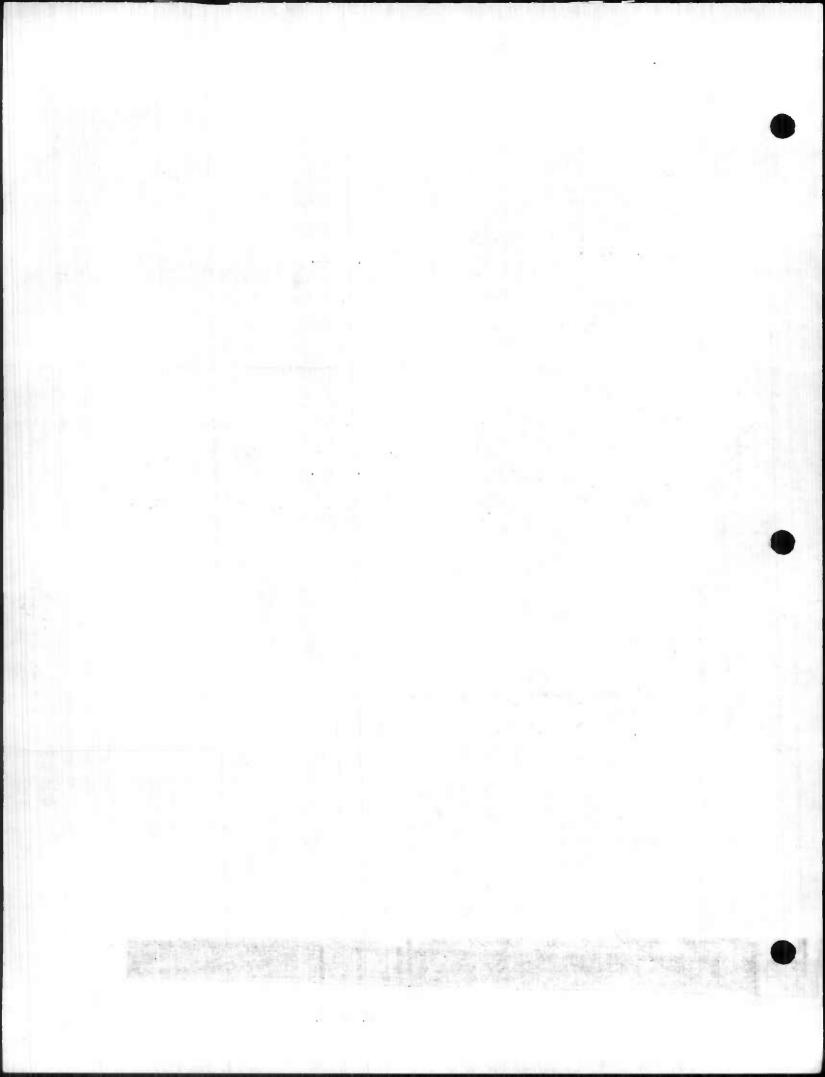
To the Hospital or within 24 hours of To the Funeral D completely filled I

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State of Maryland / Department of Health and Mental Hygiene

| | | | | | | | | Certific | cate o | f Deatl | h | | Reg. No. | | |
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| Physician | | I. Decedent's Ner | | | | | | | | | | 2. Dete of De Month | ath Day | Year | 3. Tima of Death |
| /Medical | 1 | | a The | | | | d | | | | | Janua | ary 18 | 2000 | 2:55pm |
| Examiner | | la Facility Name | | | | | | | | | | ocation of Deat | 4c. County | of Death | |
| | | Stel | la Mar | is | Hosp: | ice | | | | | oni | | | timo | re |
| eral | | Social Security | | 6. Sex | M 2MF | | yrs. last birtl | Mor | Inder 1 Yearths Day | | er 24 Hrs. Min. | 8. Dete of Bir (Month, Da | th Year) 0, 1908 | 9. Birthp | lece (State or Foreign |
| ector . | - | 262-62- | | | IN EXT | 91 | Y | rs. | | | | Nov. 1 | 0, 1908 | Ire. | land |
| | | Jsual Residence (10a. Steta | 10b. County | | | 100 | City, Town | or Location | | | | | | 1 | 0d. Inside City Limits |
| | - | MD | Balt | | re | | Timon | | | | | | | | 1 Yes 2√ No |
| Director | 1 | Oa. Street and Nu | | IMO. | | | TIMOT | | Tin Code | | | | 10a Chinas of | 140-1 C | 4.5 |
| ä | | 2300 I | | 37 37 | allev | , Pd | | 10 | 2109 | | | | 10g. Citizen of | S.A. | nry ? |
| Funeral Director | | | ou Lane | | 12. Wes Dec | | 2110 | 12 Wee D | | | Inicia? (Se | positu Vas er No | | e - Americ | an Indian |
| 5 | , | 1. Merital Status | πied 2 Man | | Armed Fo | orces? | 0,3. | If Yes, | specify C | uban, Mexica | an, Puerto | pecify Yes or No Pican, etc.) | | ck, White, | |
| by | | | 4 Divorced | | If Yes, Gi | ive evi | | 1 🗆 Y | es ŽÜN | lo Specifi | y: | | Specif | w: Wh | ite |
| | | 014 111001100 | 15. Deceden | | | Autos. | 16a | Decedent's | Henal Occ | runation | | | 16b. Kind of B | usiness/Inc | fuetry |
| Completed | | | cify only highe | st grade | completed) | | | (Give kind o | of work don | ne during mo ired) | ost of worl | king | TOO. KING OF D | 0011100001111 | ,000.19 |
| E SELO | | Elementary/Sec 12 | ondary (0-12) | | College (| 1-4or 5+) | | cial | | | | | Healt | h Ca | ire |
| | | 7. Father's Name | (First, Middle, | Last) | | | | | | 18. Mot! | har's Nam | ne (First, Middle | | | |
| o Be | | Clare | ence R | van | | | | | | A | nn | (Unkno | own) | riga (| |
| F | • | 19a. Informant's N | | | ne Print) | | 10h | Mailing Add | trace (Stre | | | ral Route Numb | | State Zin | Code) |
| | | Richard | | | | TT / So | | _ | | | | , Shre | | | |
| | 2 | Oa. Method of Dis | | 1110 | cia, i | | b. Place of | Disposition | (Name of | | | Date | 20c. Location | | |
| | " | 1 Burial 2 | Cremetion | | emoval from | State | Yorkto | owne (| aske | ts, In | | Jan. 20, | | | |
| | | | 5 Other (S | | 0 | | Cremat | lon | Serv | ice | | 2000 | York, | PA . | 1/404 |
| DOS | 21. Signature of Funerak Service Licensee 22. Name and Address of Fecility J.J. Hartenstein Mortuary, Inc. | | | | | | | | | | | | | | |
| | | * X/as | in a | N | he fory | | | 24 | Seco | ond St | , | New Fre | edom. | PA] | L7349 |
| | | 23a. Pert1. Enter shock, or he | the disease, or art failure. List | complic | canona tuit o | calised the c | death. Do no | ot enter the | mode of c | tying, such a | s cardiac | or raspiratory a | rrest, | - ! | Approximate tntarval Batween |
| an | | | | | 1 0 | 1 | | | | 8515 | | | | | Onset end Deeth |
| al er | 1 | mmedieta Causa diseese or conditi | on | | | - | 1/5/2 | 710. | The same | 02.17 | | | | | |
| | | resulting in death) | | • | | Due | to (or as a co | onsequence | of): | III- | | 1115 | 7 | | |
| Examiner | | | | - 6 | | | | | | | | | | , | |
| Eam | | Sequentially list of | onditions, | ~ " | | Due | to (or as a co | onsequence | of): | | | | | | |
| | | Sequentially list of fany, leeding to it cause. Entar Und Cause (Disease of thet initieted event | erlying | | | | | | | | | | | 1 | |
| edical | E | het initieted event resulting in death) | ls Last | C. | | Due t | o (or as a co | onsequence | of): | | | | | | |
| clar/Medical Examir | | | | L, | | | | | | | | | | | |
| 200 | | | | | | | | | | | | | | 1 | |
| , Physici | F | art II. Other eigni | | | | | | | | given in Par | t I. | 23b. Dld | tobacco una co | ntribute to | the cause of death |
| Physician | | · Ce. | 25 3/1 | 42 | 53 | 351 | pe | i/erz | | | | 10 | Yea 2 No | 3 Prol | bably 4 Unknow |
| by | | 1 | 60 | | 62/04 | 2 . | | | - | | | | | | |
| Completed | | . 142 | 7-2- | | | | | | | | | 24e. Was | an autopsy | avi | ere autopsy findings ailable prior to |
| Die | - | | | | | | | | | | | 14 | | of . | mpletion of cause death? |
| Сотр | | | | | | | | | | | | 10 | Yes XXNo | 10 | Yes 2□ No |
| To Be C | | 5. Was case refe | rred to medica | f | | | + | | | 26. Pla | ca of Dea | th (Check only | one) | 1 | |
| 0 | | axaminer? 1 ☐ Yes 2 ② | No | Н | ospital: | Innetient | 2 ER/Out | patient 3F | DOA | Other | | ome 5 ☐ Rasi | | ner (Specif | v) |
| _ | | 7. Manner of Dea | | | | | | me of | | | | | how injury occur | | ,, |
| tion of | 27. Manner of Death \$\frac{1}{N}\text{Netural} 5 \text{Pending} \text{(Month, Day Year)} 28b. Time of \text{Injury} \text{Work?} \text{1} \text{Yes} 2 \text{Lime of Injury} \text{North} \text{North} \text{Vork?} \text{1} \text{Yes} 2 \text{Lime of Injury} \text{Month} \text{Vork?} \text{1} \text{Yes} 2 \text{Lime of Injury} \text{Vork?} \text{Vork?} \text{Lime of Injury} \text{Vork?} \text{Lime of Injury} \text{Vork?} \text{Lime of Injury} \text{Vork?} \text{Lime of Injury} \text{Vork?} \text{Lime of Injury} \ | | | | | | | | □No | | | | | | |
| Certification: | | 3 Suicide | 6 Could | | 9 28 Slave of lainer At home form about feature efficient | | | | | Ce | | | on (Street and Number or Rural Route Number, | | |
| T | | 4 Homicide | Gotom | determined 288. Place of Injury - At noma, farm, street, factory, office | | | | | | | City or To | wn, Stete) | | | |
| Medical Ce | | 29a, Certifier | 1/X Certifyin | a Physi | ician: To the | best of my | knowledge | death occu | rred at the | tima date a | eonfahre | , and due to the | causa(s) and m | anner as si | tated |
| edical | | (Check only one) | | | er: On the b | | | | | | | rred et tha time, | | | |
| ₩ ¥ | 29b. Signeture and tifle of certifier 29c. License number | | | | | | | | | 29d. Date signe | | | | | |
| | Nakhuda M.N D 15504 | | | | | | | | | | | | | | |
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| 1 | 3 | 0. Neme and add | | | | | | | | 7.7 | - | m ! | . 1 | | |
| | - | Eddie | | | | | 00 Du | ilane | y Va | lley | Rd | Timor | ium, M | 1d 21 | .093 |
| State egistrar | 3 | 1. Dete filed (Mgr | AN 2 8 2 | 2000 | A | egistrar'a S | A L | 9 | lone ! | // | | | | | |
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Registrar



| | | State | of Maryland | | rtificate d | | | | leg. No. | 0 | 2261 |
|--|--|---|--|-----------------------------|------------------------------------|----------------------------------|------------------------|---|----------------------------------|-----------------------------|---|
| Physician /Medical | Decedent's Nama (First, Midel ALBERTA | | FREEMAN | | | | | 2. Date of Dea JAN 9, | | Year | 3. Time of Death 5:35 am |
| Examiner | 4a Facility Nama (If not institution SOUTHERN MARY | - | | | | | own, or Li | ocation of Death | 4c. County PRINC | | RGES |
| Funeral Director | 5. Social Security Number 169–32–8951 | 6. Sax 1□ M 2√XF | 7. Aga (In yrs. las 58 | st birthday) Yrs. | If Under 1 You Months De | | Min. | 8. Date of Birth (Month, Day FEB 23 | ,1941 | 9. Birthpl Count VIRG | ace (Stata or Foreign) INIA |
| , | Usual Rasidence of Decedant 10a. Stata 10b. Count | | 10- 00- | Town or Lo | | | | - | | I | |
| of a po | | | | | | | | | | | Dd. Inside City Limit |
| or 28a-fr be notifie Directo | PA 10e. Street and Number | | PI | ALLADI | ELPHIA | les. | | | 0-011 (111 | | |
| | 5140 DELANCEY | ST | | | 10f. Zip Cod | | | | Og. Citizen of V UNITED | | - |
| # 23 | 11. Marital Stetus | | cedent Evar in U,S. | 12.1 | | | rigin? /Sn | acifu Vac or No. | | e - America | |
| ir, or here 23s traminer must by Funeral | 1 Navar Marriad 2 Me 3 Widowed 4 Divorce | rried 1 ☐ Yea | orces? 2 ∰ No iiva | | If Yas, specify (| | | ecify Yas or No- Rican, atc.) | | k, Whita, e | |
| | 15. Deceda | nt's Education | | 16a. Deced | dent's Usual Oc | cupation | | | 16b. Kind of Bu | usiness/Ind | ustry |
| Ner than "natural, it, the Medical. Completed | | st grada completed | (1-4or 5+) | (Give | kind of work do DO NOT use re | ne during mo tired) | st of work | ing | | | |
| The D | 12 | Collega | (1-40r 5+) | SECF | RETARY | | | | CITY O | F PHI | LADEPHIA |
| Be C | 17. Fathar's Name (First, Middla | , Last) | | | | 18. Moth | er's Nem | e (First, Middle, I | Maiden Sumam | 10) | |
| Ic s | OTIS WILLIAM | S | | | | ELLA | WIL | SON | | | |
| 1 | 19a. Informant's Name/Ratation | | | 19b. Meilir | ng Address (Str | | | al Routa Number | , City or Town, | State, Zip | Code) |
| 27 | ENOR WILLIAMS | / SON | 9 | 9406 E | INE VI | EW LANE | E.CLI | NTON, MD | 20735 | | |
| 報 | 20a. Mathod of Disposition | | 20b. Pla | ce of Dispo | sition (Name of matory or other | F | 1 | | 20c. Location - | City or To | wn, State |
| T O O | 1 Surlai 2 Cremetion 4 Donation 5 Other (| | | | CEMETI | | 1 | -15-00 | FERNWOO | OD, P. | A |
| and and | 21. Signature of Southral Service | | m 833 | 22 | 2. Namp and Ad | kineen of Faci | lity DOI | PE FUNER | AT HOME | | |
| FER | > (10xx | 10002 | 77 | | | | | FOREST | | | 4.7 |
| sician | 23a. Pert1. Entar tha diseesa, o shock, or haart fallure. Lis | | | , | ar tha mode of | dying, such e | s cardiac | or respiratory arr | est, | t | Approximate Intervat Between Onset and Death |
| miner | disaasa or condition rasulting in daath) | a | ALCINOM, | | - | | | | | 1 | |
| ةِ الله | - 107 | | Doe to (or a | as a consec | juence or): | | | | | 1 | |
| the bunk-transit | Sequentially list conditions, if any, leeding to immadiata causa. Enter Undarlying | b. —— | Dua to (or a | as e consec | juence of): | | | | | | |
| ு வ த | Cause (Disease or trijury that initiated events resulting in deeth) Last | С | Dua to (or a | is a conseq | uence of): | | | | M | | |
| of for use as the for use as the for use as the for use as the form of the for | W | d | | | | | | | | 1 | |
| Sich of for | Part II. Other significant conditi | ons contributing to d | leath but not rasulti | ing in the u | nderlying causa | given in Part | l. | 23b. Did to | bacco use co | ntribute to | the cause of deati |
| gned by me attending be detached for use a by Physician/M | Pisuna | Effesion | , | | | | | 1 🗆 Y | es 2 No | 3 Prob | ebly 4 Unkno |
| 2 should | | | 400 | | | | | 24a. Was a perform | | ava | re autopsy findings ilable prior to npletion of cause leath? |
| sage 2 | | | | | | | | 1 U Y | es 200 No | 10 | Yes 28 No |
| ĕ ŏ © | 25. Was casa rafarred to medical | ı | | | | 26. Plac | e of Deat | h (Check only on | | | |
| direct To B | axaminar? 1 ☐ Yas 2)⊠ No | Hospitat: | Inpatient 2 El | R/Outpatien | t 3D DOA | Other | | me 5 Reside | | er (Specify |) |
| ne L | 27. Manner of Deeth 1 Netural 5 Pandi 2 Accident Invast | 28a. Data | | 8b. Time of Injury | 28c. t | njury at Work? | | 28d. Describe ho | | | |
| al Director: After to de in by the funeral Certification: | 3 Suicida 6 Could 4 Homicide deterr | nined 288. Plac | e of Injury - At hom ling, atc. (Specify) | ne, farm, str | eet, factory, off | се | | 28f. Location (Si City or Town | treet and Numb n, Stata) | er or Rum | Routa Number, |
| To the Funeral Director: All completely filled in by the funeral Medical Certification | 29e. Certifier 1 Certifyi (Check only one) 1 Medical | Physician: To the Examiner: On the band man | a best of my knowled pasis of axamination nnar stated. | edge, death n and/or inv | occurred at the | a time, data e ny opinion, de | nd place, ath occur | and due to the cred at the tima, d | ause(s) and ma ate and place, | nner as st | ated. the cause(s) |
| Toth | 29b. Signetura and titla of certific | "lult M | 1) | | 29c. Lic | D 5 388 | 35 | 2 | 9d. Data signed | 1 / 200 | |
| 8) | 30. Nama and addrass of person Dr VENKAT - S. | 1/ | | (Type, | - // | AD # | 307 | CLINTO | N AL | 20 | 735. |
| State Registrar | 31. Data filed ANTh, Pay You | 00 32 | Registrar's Signatur | 4 | Asa v | , | | | | | |

DHMH 16 Rav 6/95

1814 1 2 2000

State of Maryland / Department of Health and Mental Hygiene | \(\cap \) Certificate of Death 1. Decedent's Nama (First, Middia, Last) 2. Data of Death 3. Time of Death Day Month Yaar Physician 21 2000 /Medical or Location of Death 4a Eacility Nama (If not Institution, give street and number) 4b. City. Town 4c. County of Death **Examiner** MO N000 W, if Undar 24 Hrs. Hours Min. If Undar 1 Yaar 5. Social Security Number 6. Sax 7. Aga (In yrs. last birthday) Birthpiaca (Stata or Foreign Country) Data of Birth (Month, Day, Year) **Funeral** Days 1 ☐ M 2 💢 F Yrs. Director 578-72-2927 46 August 7, 1953 WASHINGTON, DC Usual Rasidence of Decedant 10a Stata 10b. County 10c. City, Town or Location 10d. tnside City Limits the Maryla: WASHINGTON, D.C. 1 ☐ Yas 2 ☐ No Director 28a-f 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 8 Hams 23a 925 Ingraham ST NW 20011 UNITED STATES OF AMERICA death Funeral 12. Was Decedant Evar in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-if Yas, spacify Cuban, Maxican, Puarto Rican, atc.) Race - Amaricen Indian, Biack, Whita, atc. Pages 1 and 2 should be filed within 72 hours after 1 Nevar Married 2X Married 1 ☐ Yas 2 ☒ No If Yas, Giva Yaar or Datas: Baltimore, Maryland 21215-0020 "natural", or 1 □ Yas 2 No BLACK Specify: by 3 ☐ Widowed 4 ☐ Divorced Hygiens. other than *natura ent, the Medical E Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working iifa. DO NOT usa retired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 11th grade OFFICE ADMINISTRATOR GOVERNMENT 17. Fathar's Nama (First, Middia, Last) 18. Mothar's Nama (First, Middla, Meiden Sumema) and Mental marked unaffic ev LEO FOSTER PERNELL JONES 19a. informant's Name/Ralationship (Type, Print) 19b. Malling Addrass (Straat and Number or Rural Routa Number, City or Town, State, Zip Coda) # Department of Health at Important: If Item 27 is any injury or other trea. 2008. PERNELL JONES / MOTHER 1201 7th ST NW #303 WASHINGTON, DC 20001 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Mathod ot Disposition 20c. Location - City or Town, Stata N Burial 2 ☐ Cramation 3 ☐ Ramoval from State 5 ☐ Othar (Specify) 1/18/00 Harmony Memorial Pk. Landover 21. Signatura of Junarai Sarvice Licensaa 22. Nama and Addrass of Facility JOHNSON & JENKINS FUNERAL HOME 716 KENNEDY ST NW WDC 20011 23a. Part1. Enter the disease, or complications that ceused the death. Do not anter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onsat and Death **Physician** /Medical tmmediata Causa (Final disaasa or condition rasulting in daath) Examiner Dua to (or as a consequence of): The law requires that the death certificate be executed Sequantially list conditions, if any, leeding to Immadiata cause. Entar Underlying Causa (Disaase or injury that initiated avants resulting in death) Last Dua to (or as a consequence ot) ending physician i Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence ot): signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Dfd tobacco use contribute to the cause of death? Probably 4 Unknown 1 ☐ Yes 2 ☐ No þ ate hes been si page 2 should Completed 24b. Wara sutopsy findings available prior to 24a. Was an autopsy completion of cause of death? 20 No this certificate 1 Yes 1 ☐ Yas 2 ☐ No Hospital or Attending Physician: 24 hours efter death. Et hours Director: After this certificately filled in by the funeral director; Be 25. Was casa ratarred to medical 26. Placa of Death (Check only ona) axaminar? Other: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) 2 22 No 1 Yas 1 Inpatiant 2 ER/Outpatient 3 DOA 27. Menner of Daath 28a. Data of Injury (Month, Day Year) 28b. Tima of 28d. Dascribe how injury occurred Certification: 28c. fnjury at Work? 5 Pending invastigation Neturel 1 ☐ Yas 2 ☐ No 2 Accidant 3 Sulcida 6 Could not be 28f. Location (Streat and Number or Rural Routa Number, City or Town, Steta) 28a. Place of Injury - At home, tarm, streat, tactory, office building, etc. (Specify) 4 Homicide To the Mospital c within 24 hours of To the Funeral D completely filled Certifying Physician: To the best of my knowledge, death occurred at tha time, data and place, end due to the cause(s) and mannar as stated.

| Medical Examtner: On the basis of axeminetion and/or invastigation, in my opinion, death occurred at tha time, date and place, and dua to the cause(s) and mannar stated. Medicai 29a. Certifier (Check only one) 29b. Signatura and titla of certifier 29c. Licensa number 29d. Data signed (Month, Day, Year) 2000 30. Nama and addrass of person who complated causa of death (itam 23a) (Type, Print)

32. Ragistrar's Signature

Registrar

State

1.2

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene \(\) Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death Month Physician VARUARY 2000 6:15 AM 6 /Medical 4a Facility Nama (If not Institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGES HOSPITA If Under 24 Hrs. 8. Data of Birth Min (Manth, Day, If Undar 1 Year Social Security Number 6. Sex 7. Aga (In yrs. last birthday) 9. Birthplaca (Stata or Foreign **Funeral** 63 Yrs. Months Days Country); 1 M 200 F 3350 Director Usual Rasidance of Dacedant 10d. Inside City Limits 10a. Stata 10b. County 10c. City, Town or Location 1 Yes 2 No CAPITAL Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 6 U.S.A. 238 Funeral 12. Was Decedent Evar in U.S. Armed Forcas? 1 ☐ Yas 22 No If Yas, Giva Yaar or Datas: 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) Race - Amarican Indian, Black, Whita, etc. 11. Marital Status 1 Nevar Married 2 Married 1□ Yas 2 No Specify: B/ACK "natural", or Specify. Be Completed by 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business Industry LA FAST PIAZA 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highast grada completed) Elementary/Secondary (0-12) College (1-4or 5+) OUSEKEEPER DOMESTIC 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middla, Maidan Sumama) HARRY LEE ERNESTINE THORNHILL 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) AUI Q. FORD 913 Clovis AVE CAPITAL HOTS, MD. 20743 HUSDAND 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata Burial 2 Cramation 3 Removal from Stata CEM, 4 ☐ Donation 5 ☐ Othar (Specify) 22. Nama and Addrass of Facility HUNT 21. Signatura of Funaral Sarvice Licensee Bernara 908 KENNEDY ST. N.W. WASh. D.C. 20011 23a. Part1. Entar tha diseasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediata Causa (Final FAILURE MULTIORGAN DAYS diseasa or condition resulting in death) Examiner Due to (or as a consequence of): Physician/Medicai Examiner Sequentially list conditions, if any, laading to immadiata cause. Enter Underlying Cause (Disaase or Injury that initiated evants resulting in death) Last Dua to (or as a consequence of): RESPIRATURY DISTRESS ADULT STNOLOME Dua to (or as a consequence of): ASPIRATION PNEUMONIA 4 weals Part II. Other significant conditions contributing to death but not rasulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 55 MELLI TUS Be Completed by 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? HYPERT ENSION 1 Yes 2 No 1 ☐ Yas 2 ☐ No certificata or Attending Physician: 25. Was casa refarred to medical examiner? 26. Place of Death (Check only ona) 1 Yas 2 7 No Other: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) edical Certification: To 1 Inpatiant 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 28d. Dascribe how injury occurred 28c. Injury at Work? After 5 Panding Invastigation 1 Yas 2 No within 24 hours after death. To the Funeral Director: A 2 Acidant 6 Could not be datermined 3 Suicida 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) filled in by 4 | Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifiar (Check only

To the

DHMH 16 Rav 6/95

Records, P.O. Box 68760,

Division of Vital

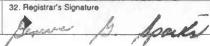
State Registrar

1 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and tall of certifie

31. Data filed (Month, Day, Year)



HODMERCAR

ORIGINAL

29c. License number

29d. Data signed (Month, Day, Year)

#135, LAPGO, MD 20774



State of Maryland / Department of Health and Mental Hygiene | | Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Date of Death **Physician** Day Yaar LAURA MAE FLANIGAN JANUARY 6, 2000 10:30 PM /Medical 4e. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 325 KING REIS LANE DEER PARK GARRETT 5. Social Sacurity Number If Undar 1 Yaar If Undar 24 Hrs. 9. Birthplaca (State or Foraign 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, **Funeral** 1 □ M 2 F Deys Hours 212-32-7926 JULY 19, 1894 105 Yrs MARYLAND Director Usual Rasidance of Decadent the Maryland show 10a Stata 10b. County 10c. City, Town or Location to or 28a-f show 10d. Insida City Limits 1 Yas 2 No Director MD GARRETT DEER PARK 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? "natural", or items 23a 325 KING REIS LANE 21550 USA by Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene.
Into: If item 27 is marked other than "natural", or items 23 mry or other traumatic event, the Neutral Earn manner. 12. Was Decedant Ever in U,S. Armed Forces? 1 ☐ Yas 2X No If Yes, Giva Yaar or Datas: Was Dacedant of Hispenic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxicen, Puerto Rican, atc.) Race - Amarican Indien, Black, White, atc. 1 ☐ Navar Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: WHITE 3 X Widowed 4 □ Divorced Completed 15. Dacadant's Education (Specify only highest grada complated) 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) Coltaga (1-4or 5+) HOUSEKEEPER & COOK HOTEL 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Name (First, Middla, Maidan Sumama) **JOSEPH** FRIEND ELIZABETH ANN FRIEND 19a. Informant's Name/Retationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Coda) BETTY BECKMAN - DAUGHTER 18848 GARRETT HIGHWAY OAKLAND, MD 21550 20a. Mathod of Disposition 20b. Place of Disposition (Name of cematery, cramatory or other place) Data 20c. Location - City or Town, Stata 1X Burial 2 ☐ Cramation 3 ☐ Ramovat from Stata Department of Important: If any Injury or GARRETT MEMORIAL GARDENS 1/9/2000 OAKLAND, MARYLAND 4 ☐ Donation 5 ☐ Othar (Spacify) rice Licepser 22. Name end Addrass of Facility P.O. BOX 243 M00167 DURST FUNERAL HOME - OAKLAND, MD 21550 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** /Medicai CONGESTIVE Immadiata Cause (Final HEART FAILURE disaasa or condition rasulting in death) L years Examiner Due to (or as a consequence ot) Examiner Sequentially list conditions, if any, teading to immadiata ceusa. Enter Undarfying Causa (Disaasa or injury that initiated avants resulting In daath) Last and Due to (or as a consequence of): The law requires that the death certificate be execu Box 68760, Physician/Medicai Dua to (or as a consequence of) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Kewrent Urinary Tract Division of Vital Records, by 24b. Ware autopsy findings availabla prior to completion of ceusa of daath? Completed 24a. Wes en eutopsy performed? certificate 1 ☐ Yas 2 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Was cesa reterred to medical axaminer? Be 26. Place of Death (Chack only ona) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 A Rasidance 8 Other (Specify) Medical Certification: To 1 Yas 2 X No this funeral 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. tnjury at Work? 28d. Dascribe how Injury occurred After 1X Natural 5 Pending death. 1 ☐ Yas 2 ☐ No investigation 2 Accidant after death in by the 3 Suicida 6 Could not be detarmined 28e. Place of Injury - At homa, farm, streat, tactory, office building, atc. (Spacify) 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 4 Homicide 24 hours a 12 Certifying Phyalcian: To the best of my knowladga, daath occurred at tha time, data and place, and dua to the cause(s) and manner as stated.
2 Madical Examiner: On the basis of axamination and/or invastigation, in my opinion, daath occurred at tha time, data and place, and dua to the causa(s) and menner stetad. 29a, Cartifiar within 24 hou To the Fune completely fi To the 29b. Signature and title of certifier 29c. Licensa number 29d. Data signed (Month, Day, Year) D27205 00 30. Name and addrass of person who complated ceuse of death (Itam 23a) (Type, Print) KARL SCHWALM, M.D. 311 N. FOURTH ST. OAKLAND, MD 21550

DHMH 16 Rev 6/95

State

Registrar

31. Data filed (Month, Day, Yaar)

JAN 1 0 2000

32. Ragistrar's Signatura

State of Maryland / Department of Health and Mental Hygiene

| KARFN F | WLER | Cer | tificate of | Death | | Reg. No. | 0 02265 |
|--|--|--|---|---|--|------------------------------|---|
| Physicia | NAKEN GENEVA EUWLEK | | | | 2. Data of De Month JANUAF | | 3. Time of Death |
| /Medic Examine | de Franklin, blance defende in sette eller miles administration | BLVD | | b. City, Town, or L CAPITAL | | | of Death CE GEORGES |
| Funeral Director | 5. Social Security Number 185 – 38 – 6304 1 □ M 2 M F | 7. Aga (In yrs. last birthday) 51 Yrs. | If Under 1 Yaar Months Days | If Undar 24 Hrs. Hours Min. | 8. Data of Birt (Month, Da April 1 | th y. Year) 1948 | 9. Birthplaca (Stata or Ford Country) New Jersey |
| pu k | Usual Rasidance of Decedant 10a. Stata 10b. County | 10c. City, Town or Loc | cation | | | | 10d. Inside City Lim |
| Mary H sho | Maryland Prince George's | Capitol | Heights | | | | 1 X Yas 2 □ |
| th the | 10e. Street and Number | | 10f. Zip Code | 16701E | | 10g. Citizen of V | Vhat Country? |
| 23a w | 1229 Capitol Heights | | 20743 | | | U.S.A | ۹. |
| 0.5 E | 1 Nevar Married 2 Married 1 Yas 1 Widowed 4 Divorced Yasr or D | 2 🔀 No | Vas Decedant of H Yas, specify Cuba | lispanic Origin? (Sj an, Maxicen, Puarti Specify: | pecify Yas or No Rican, atc.) | 14. Race Blec Specify | e - Amarican Indian, kk, Whita, atc. r: Black |
| VITTS-0020 Within 72 hours at ane. Dan Traturaf, or De Medicel Exam | 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1) 12th 17. Father's Name (First, Middle, Last) Emerson Garfield Hunl | | lant's Usual Occup kind of work dona OO NOT usa retired al Secre | ation during most of word tary | king | 16b. Kind of Bu | usiness/Industry |
| land 2 | 17. Fathar's Nama <i>(First, Middla, Last)</i> Emerson Garfield Hunl | | | 18. Mothar's Nam | | Maidan Sumam | |
| Mar nd 2 sho sith and 27 is ma r traum | 19a. Informant's Name/Ralationship (Type, Print) Chantee Dixon/Daughter | 1403 | Nova Ave | | | | Stata, Zip Code) hts, MD 2074: |
| Limore, Pages 1 a ment of He ment If Nam dury or other | 20a. Mathod of Disposition 1 ☐ Burial 2 🛣 Cramation 3 ☐ Ramoval from 4 ☐ Donetion 5 ☐ Other (Specify) | Stata 20b. Piace of Dispose cematary, cram Chesapeak | | | 01/07 2000 | | City or Town, Stata |
| Description of the control of the co | 21. Signatura of Funeral Sarvice Licensea Perc 23a. Part1. Entar tha disaasa or complications that of shock, or haart failura. List only one ceuse on e | entie J. | 74 Lando | NS FUNER | Landov | ver, Mar | yland 20785 Approximate Interval Between Onsat and Death |
| Physician /Medical Examiner | Immediata Causa (Final disease or condition rasulting in death) | Dua to (or as a consequent | TAB WU | nds | | | |
| S/D/ Sate be shysicie the bu | Sequantially list conditions, if any, laeding to immadiate ceusa. Entar Undarlying Cause (Disaase or injury that initiated avants rasulting in death) Last | Dua to (or as a consequence of the consequence of t | | 4 | | | |
| BOX ath cer attendir for use | d | | | | | | 1 |
| | d Part II. Other algorificant conditions contributing to de | eath but not resulting in the un | ndarlying causa giv | an in Pert I. | | Yss 2 No | ntribute to the cause of dea |
| NECOTOS, | | | | | | an autopsy rmed? | 24b. Wara autopsy finding available prior to completion of cause of daath? |
| The late has page | | | | | 100 | Yas 2 No | 1X Yes 2□ No |
| yysician: The lew hysician: The lew his certificate has t I director, page 2 s | 25. Was casa rafarred to madical axaminar? | | 100 | 26. Piaca of Dea | th (Check only o | ona) | |
| | P 1 Yas 2 No Hospital: 1 □ | npatient 2 ER/Outpatient | t 3□ DOA Oth | 4 LI Nursing H | 4.5 | dance 6 Oth | |
| Mending Phy deeth. doc: After this the funeral | 27. Mannar of Death 1 Natural 5 Panding Non-Accident Invastigation | of Injury (1644) 28b. Tima of Injury | PM 10 | Yas 2X No | | how injury occur O AT RE. | |
| > 4 5 6 6 | 3 Sulcida 6 Could not be determined 28a. Place | of Injury - At homa, farm, streng, atc. (Specify) | eet, factory, office | | 28f. Location (| | per or Rural Routa Number |
| Hoepk 14 hour Funer tely fill | 29a. Cartifiar 1☐ Certifying Physician: To tha (Check only 2☑ Medical Examiner: On the box | best of my knowledga, daath | occurred at tha tir | | , and dua to the | causa(s) and ma | nnar ss stated. |
| To the within 2 To the comple | 29b. Signatura and titla of certifiar | n.D. | 29c. Licans O.C. | | | | 04 , 2000 |
| (10) | 30. Nama and addrass of person who complated caus | | Print) | ATT COL | | | |

State Registrar

JACK M. TIMS, MID

111 Penn Street, Baltimore, Maryland 21201

DHMH 16 Rsv 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 0 2 2 6 6

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| | | | | ent of | Health and | Mental Hyg | _ | 0 (| 12267 |
| 1. Decedent's Nama (First, Middla, L. | ast) | | | | 11 11 | 2. Data of Das | | | 3. Tima of Death |
| 1. Dune 1 | . GILD | 01 | | | | Month | Day Oc | Yaar | 5:20 Am |
| 4a. Facility Nama (If not Institution, gi | va straat and number) | 209 | | 1 | 4b. City. Town, o | or Location of Death | | | J. ACAM |
| Charles County | 111 | Rehah | Conto | 20 | La Pla | | Char | | |
| | | a (In yrs. last bir | | ndar 1 Yaa | | | | | ace (Stata or Foreign |
| | 10 M 2□F | | Yrs. Mon | | | in. (Month, Day | 1958 | Count | |
| 10a. Stata 10b. County | | 10c. City, Tow | n or Location | | | | | 10 | d. Insida City Limits |
| MD Char | rles | I | a Pla | ata | | | | | 1 X Yas 2 □ No |
| 10e. Street and Numbar | | | | | | | 0.00 | | |
| | | | 101. | . Zip Coda | | | I Og. Citizen of V | Vhat Count | ry? |
| 10200 La Plata | | | | 2064 | | | USA | | |
| 11. Maritai Status | 12. Was Dacedant Armed Forças? | | 13. Was Do | ecedant of specify Cul | Hispanic Origin? pan, Maxican, Pu | (Specify Yas or No- arto Rican, atc.) | | e - Amarica k, Whita, a | |
| 1X Navar Marriad 2 ☐ Married 3 ☐ Widowad 4 ☐ Divorcad | t □ Yas 2√01 If Yas, Giva Yaar or Datas: | No | 1 □ Ya | s 2 No | Specify: | | Specify | T 71 9 | |
| 15. Dacedant's E (Specify only highast gr | | 16a. | Decedent's I | Usual Occu | pation | unding | 18b. Kind of Bu | sinass/Ind | ustry |
| Elementary/Secondary (0-12) | College (1-4or ! | 5+) | Pair | | during most of w | TOTALING | Но | ıse | |
| 17. Fathar's Nama (First, Middla, Las | t) | | | | 18. Mothar's N | lama (First, Middle, | Maidan Sumam | a) | |
| Thomas Clark (| Gilroy, Sr | | | | Betty | Amanda | Cranda | 11 | |
| 19a. Informant's Name/Raiationship Betty Gilroy/N | | | | | | Rural Route Number | | | |
| 20a. Method of Disposition X☐ Burial 2 ☐ Cremation 3 [4 ☐ Donation 5 ☐ Othar (Speci | | cemata | Disposition or crama tory | or other pla | | Data 1/17/00 | 20c. Location - Nanje | | m, Stata Maryland |
| 21. Signature of Funaral Sarvice Lice | 01/ | M0094 | AREH | IART- | | FUNERAL | | | |
| 23a. Part1. Entar tha disaasa, or con shock, or haart failura. List only | ona causa on aach III | tha daath. Do i | not enter ine i | | | iac or respiratory and | MD. Z(| | Approximate Intarval Batween Onset and Death |
| Immadiata Causa (Final disaasa or condition resulting In daath) | a | Dua to (or as a | | | death | | | an an | |
| | Muc | | - orisoquarioo | 0.7. | | | | | |
| Sequantially list conditions, if any, leading to Immadiata cause. Enter Underlying | b | Due to (or as a | consequance | of): | | | | | |
| Cause (Disaasa or injury that initiated avents rasulting in death) Last | c | Dua to (or as a o | consequance | of): | | | | | |
| | d | | | _ | | | | | |
| Part II. Other significant conditions of | Contributing to death b | ut not resulting Ir | tha undarlyin | ng cause g | van in Part I. | 23b. Did to | - d | | the causs of death? |
| Seizwe | disord | (r | J | | | 24a. Was a perfor | | ava | e autopsy findings labla prior to plation of causa |
| | | | | | | 1 🗆 Y | as 2 No | of d | áeth? Yas 2□ No |
| 25. Was case referred to medical axaminar? | | | | | 28. Placa of D | aath (Check only or | na) | | |
| 1 Yas 2 No | Hospital: 1 Inpatia | nt 2 ER/Ou | tpatiant 3 | DOA OI | har: 4 Nursing | Homa 5 Rasid | ance 6 Othe | ar (Specify | |
| 27. Manner of Death 1 Natural 5 □ Panding invastigatio | 28a. Data of Inju (Month, Da) | y 28b. 1 | Tima of njury | 28c. Inju | | 28d. Dascribe h | | | |

Physician /Medicai Examiner

Physician

/Medical

Examiner

Director

Funeral

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Completed

To Be

Funeral

Director

with the Meryland

permit. Pages 1 and 2 should be filed within 72 hours efter death with the Marylan. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28s-f show any lighty or other traumatic event, the Medical Examiner must be northered and blace.

Baltimore, Maryland 21215-0020

27. Manner of Death

1 Natural

2 Accidant

3 Suicida

29a. Certifier (Check only one)

4 Homicida

29b. Signatura and titla of certifian

attending physician and for use as the burial-transit

Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, Physician/Medical eral Director: After this certificate has been signed by the a filled in by the funeral director, page 2 should be detached i Be Completed by within 24 hours after death.

To the Funeral Director: After this certificate has Medical Certification: To completely

> State Registrar

B. LARRY JENKINS, 31. Data filed (Month, Day, Year)

JAN 1 8 2000

6 Could not be datarminad

m.D 32. Ragistrar's Signatura

30. Nama and addrass of person who completed causa of death (Itam 23a) (Type, Print)

28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify)

III LAGRANGE AVE LAPLATA, MD 20646

D0033426

1 Cartifying Physician: To the best of my knowladge, death occurred at tha time, date and place, and dua to the cause(s) and mannar as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and dua to the cause(s) any mannar stated.

29c. Licansa number

28f. Location (Straet and Number or Rural Route Number, City or Town, Stata)

29d. Data signed (Month, Day, Year)

0000 8 1 15

Please Type or Print in Black Indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Gibson Rodney :13 AM 00 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Prince George's Clinton Age (In yrs. last birthday) 53 Yrs. If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Dey, Year) July 2,1946 Months Days Hours 447-44-9532 1⊠M 2□F Oklahoma Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits XXXes 2 No N/A Washington 10g. Citizen of What Country? U.S.A. 10e Street and Number 10f Zin Code 20010 3636 N.W. 16th Street 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yas or No-lt Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 ☐ Yes ¾XNo 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 ☐ No Specify: 3 ☐ Widowed 4 ☐ Divorced Yeer or Dates: 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Disabled N/A 12th N/A 17. Fathar's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Arlie B. Ray Gibson Ernest 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13008 Barnwell Place Upper Marlboro, Maryland 20772 Patsy Harvey (Sister) 20b. Plece of Disposition (Name of cematery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 Burial 2 □ Cremation 3 □ Removal from Stata Oklahoma City Fairlawn Cemetery January 15,200b 4 ☐ Donation 5 ☐ Other (Specify) Lee Funeral Home, Inc. 22. Nama and Addrass of Facility 21. Signature of Funeral Service 4 6633 Old Alexandria Ferry Road Clinton, MD 20735 23a. Part. Enfer the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one ceuse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final diseese or condition resulting in death) End stage Stage of Little Don dispass V.Dars Contro en consequence of: WKS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Bilateral PALOM THE Due to (or as a consequence of): stappylo roccor aureus WKS MRSAI Hepatonenal bailare Dags Part tt. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 No 3 Probably 4 Unknown portal Happitension 6 portel gastropady, ascitis 24b. Were autopsy tindings available prior to completion of cause of death? 24e. Was an autopsy performed? Dironic obstaudine palmonary discoop N/A 1 ☐ Yes 2 No 2□ No 25. Was case referred to medical examiner? condido as alar discos 28. Place of Deeth (Check only one)

Other: 4 Nursing Homa 5 Residence 6 Other (Specify)

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28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29d. Data signed (Month, Day, Year)

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Physician /Medical **Examiner**

Physician

/Medical

Examiner

Funeral

Director

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Hygiene.

Pages 1 and 2 should be fill ment of Health and Mental H lant: If them 27 is marked out

other 1 If Item

permit. Page Department of Important: If any Injury or pace.

Director

Funeral

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Completed

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death with the Manyland

filed within 72 hours after

Baltimore, Maryland 21215-0020

or Attending Physician: The law requires that the death certificate be executed and Box 68760 the USB BS Division of Vital Records, P.O. 8 certificata has funeral director. After this To the Hospital or Attending within 24 hours after death.

To the Funeral Director; After completely filled in by the fun

Examiner Physician/Medical þ Completed Be Certification: To

1 Yes 2 No

5 Pending

oter

investigation 6 Could not be determined

27. Manner of Death

1 Natural 2 Accident

3 ☐ Suicide

29a. Certifier (Check only one)

4 Homicide

29b. Signature and title of certitian

State Registrar

Medical

PETER W. Tim AM.D. 17900 old Branch 31. Dete tiled (Month, Day, Year) JAN I I 2000 32. Registrar's Signature

30. Name and address of parson who completed cause of death (Item 23a) (Type, Print)

Q.

0.82 suite 101.

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA

M.D.

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28a. Date of injury (Month, Day Year)

41in

28b. Time of

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

1 Tes 2 No

P00 12884

JAM 1 1 2000

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Gilbert Wilfred 2000 1323 **Physician** Norman JANUAKY 08 /Medical 4e Fecility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ACCO KEEK INPLAN 14306 PRINCE GERGES HEAD HIGHWA> If Under If Under 24 Hrs. 8. Date of Birth (Month, Day, Yeer) March 8,1928 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Months Hours 10XM 20 F 003-12-3185 New Hampshire Director 71 Usual Residence of Decedent with the Meryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State r than "natural", or items 23s or 28s-f show the Medical Exempler must be notified at 1 Yes 2 200 Director Maryland Prince George's Accokeek 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14306 Indian Head Highway 20607 U.S.A. Funeral death 13. Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, 11. Marital Stetus Bleck, White, etc. filed within 72 hours after XYes 2 □ No Yes, Give 1945-1 Never Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: White Specify à 3 ☐ Widowed 4 ☐ Divorced 1947 Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 8th N/A Safeway Bakery Superintendent permit. Peges 1 and 2 should be filed v Department of Heelth and Mentel Hygie Impertant: If item 27 is marked other any injury or other traumatic event, tr 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Merchier Gilbert Lillian Angilina Louis Henry 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. informant's Name/Relationship (Type, Print) Jean Marie Gilbert (Wife) 14306 Indian Head Highway Accokeek, Maryland 20607 20b. Place of Disposition (Name of cemetery, cremetory or other place) Jan. 20c. Location - City or Town, State 20a. Method of Disposition 13.2000 1 XBurlal 2 □ Cremetion 3 □ Removel from State Maryland Veterans Cemetery Cheltenham, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Lee Funeral Home, Inc. 21. Signature of Fundral Service Licenses 22. Name and Address of Facility 6633 Old Alexandria Ferry Road Clinton, MD 20735 23a. Part1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heart failure. List only one ceuse on each line. Approximate interval Between Onset and Death **Physician** /Medical Immediate Cause (Final . HYPERTENSIVE ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE disease or condition resulting In deeth) Examiner Due to (or es a consequence of): Examiner that the death certificate be executed buriel-transit end Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or es e consequence of) P.O. Box 68760, physician Physician/Medical the Due to (or as a consequence of) 28 esu ettending ŏ per Part II. Other aignificant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 120 detach 1 Yas 2 No 3 Probably 4 Unknown á signed b Division of Vital Records, by 24b. Were autopsy findings available prior to completion of cause 24a. Was an autopsy Completed peed performed' hes page 2 N/A 1 □ Yes 2 No 1 Yes 2□ No certificate Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certific director. 25. Was case referred to medicel Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28c. Injury et Work? Certification: 28e. Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Injury 1 Natural 1 Yes 2 No 2 Accident 3 Suicide 6 ☐ Could not be determined 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide 24 hours s 29e. Certifier 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated.

**Medical Examinar: On the basic of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar as stated. Medical To the Hosp within 24 ho To the Fune completely f (Check only one)

State Registrar 30. Na

GOLLE MARIO JAN 1 1 2000

29b. Signature and title of certifie

JR 3001 32, Registrar's Signeture

ed cause of de

(Item 23a) (Type, Print)

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29c. License number

29d. Dete signed (Month, Day, Year)

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Carmela Giandonato 9 Jan. 2000 6:15 P.M. 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Crofton Convalescent Center Crofton Anne Arundel If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 10 M 20 F Days Hours 221 32 6904 88 Yrs July 16, 1911 Chester, PA Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits XX Yes 2□No Maryland Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3007 Trinity Drive 20715 United States 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 전 No If Yes, Give Year or Dates: 14. Rece - American Indien Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 11 Maritel Stetus 1 □ Never Married 2 □ Married 1 Yes 2 No Specify: Specify: White 3 K Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Seamtress Uniform Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Antonio Casimir Santa Giancola 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan D'Orsaneo Daughter 3007 Trinity Drive Bowie Maryland 20715 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Jan. 11, Da2000 20c. Location - City or Town, State The Huntt Crematory Waldorf Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility Robert E. Evans Funeral Home, Inc. 21. Signature of Funeral Service Licenses 16000 Annapolis Rd. Bowie Maryland 20715 23a. Part1. Enter the disease, or complications shock, or heart failure. List only one ceuse het caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 3 days Neumonia Due to (or as a consequence of) Sequentially list conditions, if any, leading to Immediate ceuse. Enter Underlying Cause (Disease or Injury that Initieted events resulting in death) Last Due to (or as a consequence of) Due to (or as e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 ☐ Unknown mentia 24b. Ware autopsy findings available prior to 24a. Was an autopsy completion of cause of death? 2 1 No 1 Yes 1 ☐ Yes 2 ☐ No 25. Was cese referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 100 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work?

Physician /Medicai Examiner

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Physician/Medical

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1 BNatural

2 Accident

3 Suicide

29a. Certifier

4 Homleide

(Check only one)

Certification:

Medical

Physician

/Medical

Funeral

Director

Item 27 is marked other than "natural", or items 23s or 28s-f show other treumatic avant, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death v
Department of Heelth and Mental Hygiene.
Important: If item 27 is merked other than "natural", or items 23a
and injury or other treumatic avent, tre Medical

3altimore, Maryland 21215-0020

Box 68760.

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Records,

Division of Vital Attending Physician:

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physician end s the bunal-trans 88 esn 9 deteched page 2

the death certificate be executed the signed by t peen has funerel death. after death Director: ŏ 24 hours of Funeral Hospital

To the Hosp within 24 ho To the Fune completely fi

State Registrar

Schu HowardK 31. Dete filed (Month, Day, Year)

JAN 1 0 2000

29b. Signature and title of certifier

5 Pending investigation

6 Could not be

30. Name and address of person who completed ause of death (Item 23a) (Type, Print)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

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28f. Location (Street and Number or Rural Route Number, City or Town, State)

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death ieG! Month Year **Physician** SR. Gugval 306 A 11, 2000 4c. County of Death /Medical 4a Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death Examiner uvve Qua No au If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year, Min Months Days Hours 1 M 20 F 77 219-14-7342 14, 1922 Pennsylvania Apr Usual Residence of Deceden 10s. State 10b. County 10c. City. Town or Location 10d. Inside City Limits MD Garrett Friendsville 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3277 Friendsville-Addison Road 21531 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 Never Merried 2 Merried 1 Yes 2 No Specify: white 2 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade comp 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 th Dairy Dairy Farmer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) 8 Dorsey Guard Laura Fox 20 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty J. Guard/wife 3277 Friendsville-Addison Rd., Friendsville, MD21531 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition Date 1 XBurial 2 ☐ Cremetion 3 ☐ Removel from State Mill Run Cemetery, Jan 14, 2000 Friendsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Newman Funeral Homes, P.A., PO Box 275 179 Miller St., Grantsville, MD 21536 23a. Part I criter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finel disease or condition resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of): Physician/Medical that initieted events resulting in death) Last Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown p 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was en autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 8 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 12 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: 1. Netural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide

Box 68760. 8 P.O. Division of Vital Records. To the Hospital or Attending Pi within 24 hours after death. To the Funeral Director: After it completely filled in by the funer

Funeral

Director

the Maryland

pernit. Peges 1 and 2 should be filed within 72 hours efter death with the Marylan Department of Health and Mentel Hygiena. Important: If Item 27 is marked other than "natural", or frama 23s or 28a-f show any Injury or other traumatic event, the Medical Examinar must be notified.

Physician

/Medical Examine

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Baltimore, Maryland 21215-0020

State

Registrar

DHMH 16 Rev 6/95

29b. Signature and title of certifier

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

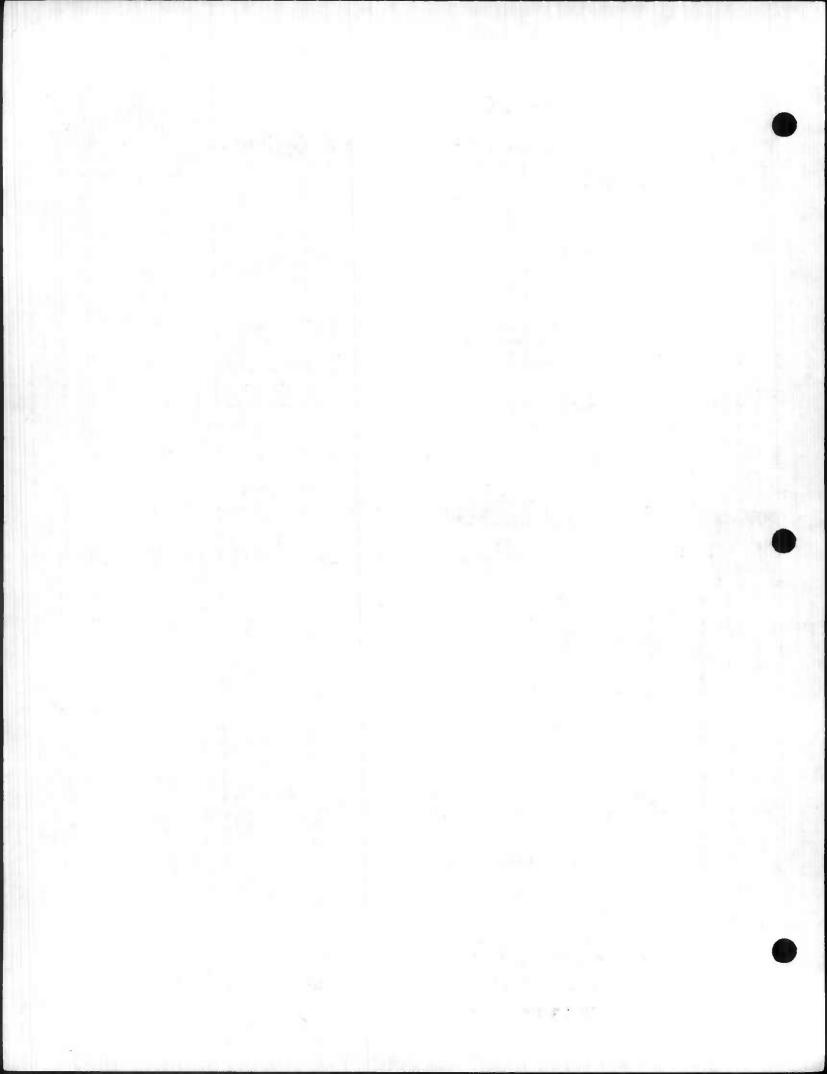
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(a) and manner stated.

29d. Date signed (Month Day, Year)

of death (Item 23a) (Type, Print) 30. Name and address of person who completed cause Danie Vac 1

31. Date filed (Month, Day, Year) 32. Registrar's Signature JAN 13 2000

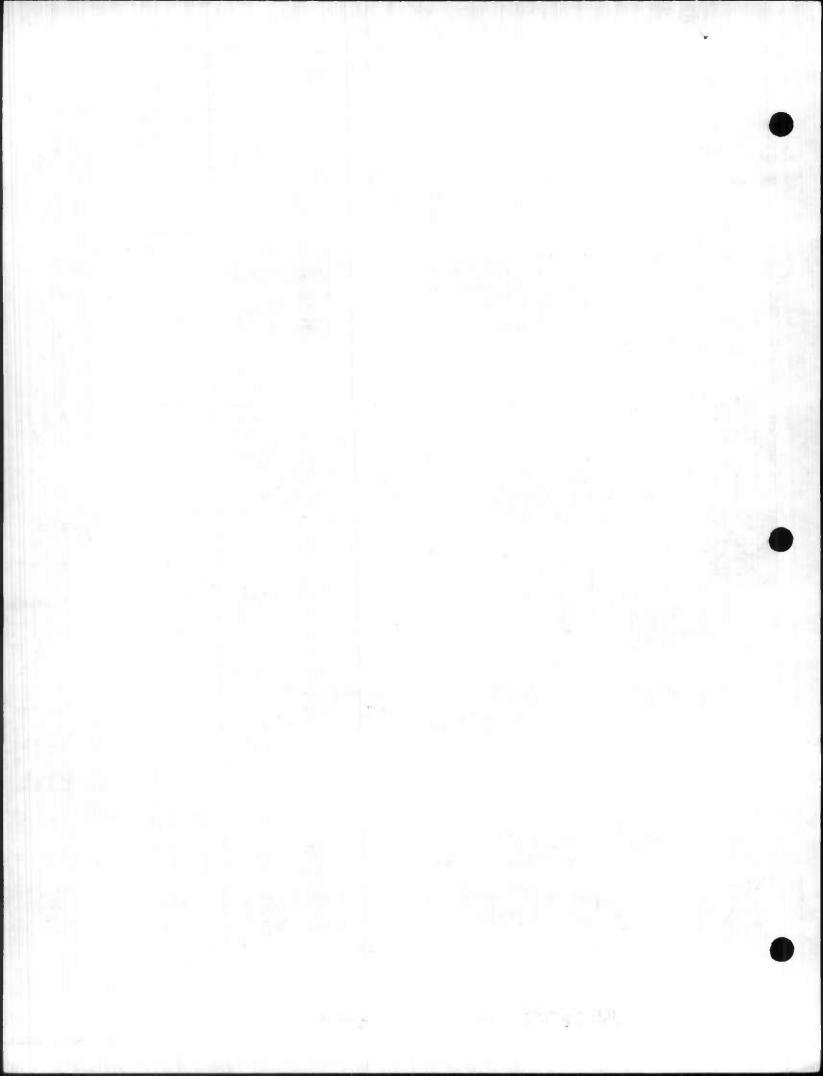
29a. Certifier (Check only onel



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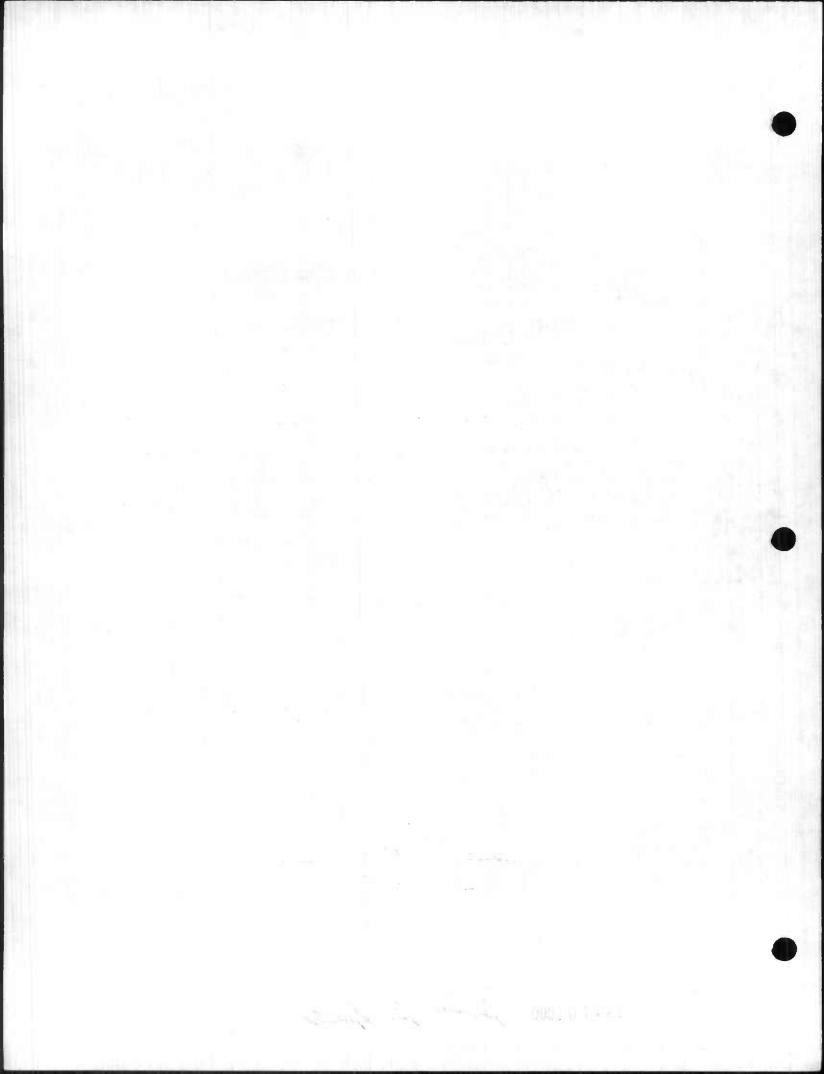
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|--|---|---|---------------------------------|--|--|--|---------|--------------------------------------|------------|--------------------------------|----------------------------------|------------|---------------------------------------|
| | | 1. Decedent's Name (First, Middle | Last) | | | | | | | 2. Date of D | eath | | 3. Time of Death |
| | hysician | JOHNNIE LEE GR | AVES | | | | | | | JANUAR | Y 14, 20 | Year | 10:22 AM |
| | /Medical | 4a Facility Name (If not institution, | give street and nu | ımber) | | | 1 | 4b. City, To | own, or L | ocation of Dee | - | | 20022 |
| | xaminer | FORT WASHINGTO | | 1 | | | | FORT | WASH | INGTON | PRINCI | | ORGES |
| | | | 6. Sex | 7. Age (In yrs. I | last birthday) | If Under 1 | | If Under | | | | | place (State or Foreign |
| | neral ector | 249-84-9879 Usuai Residence of Decedent | 1⊠M 2□F | 51 | Yrs. | Months | Days | Hours | Min. | APRIL | 26,1948 | SOU! | n(rv) |
| pul | ž == | 10a. State 10b. County | | 10c. City | y, Town or Lo | cation | | | | | | 1 | Od. Inside City Limits |
| he Mary | be notified be notified Director | MARYLAND PRINCE | GEORGES | FOF | RT WASI | 1 . | | | | | | | 1 No Yes 2 No |
| death with the Maryland | al Dir | 9512 BLANCHARD | DRIVE | | | 10f. Zip (| 207 | 44 | | | UNITED S | | |
| .0020 hours after dea | r than "natural, or fame 23s or 28s4 alow tre Medical Examera: must be notified at ompleted by Funeral Director | 11. Maritel Status 1 □ Never Merried 2 ☑ Marrie | Armed Formed 1 X Yes If Yes, Gi | 2□No 196 | 00- | Was Decede f Yes, specif 1 ☐ Yes 2 | | dispanic Or an, Mexica Specify | | ecify Yes or N Rican, etc.) | 14. Race Black Specify: | k, White, | |
| 5-0020 | d by | 3 Widowed 4 Divorced | Year or D | Dates: | | | | | | | | BLA | |
| 2 2 | it, the Medical | 15. Decedent' (Specify only highest | | | (Give | dent's Usual kind of work | done | during mos | st of work | ing | 16b. Kind of Bu | siness/Inc | dustry |
| Ind 21215- be filed within 72 tal Hygiene. | d de | Elementery/Secondary (0-12) | College (| | | DO NOT use | | a) | | | DIGENETA | D 001 | |
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| aryland should be file | marked other imatic avent, To Be C | 17. Father's Name (First, Middle, L | .ast) | | | | | | | | , Meiden Sumeme | 9) | |
| arylan should be ind Mental | To do | JOHNNIE GRAVES | | | 1 | | | | | | GRAVES | | |
| 2 4 4 | 4 5 | 19a. Informant's Name/Relationsh | ip (Type, Print) | | | | | | | | per, City or Town, | | |
| 1 and Health | 124 | | IFE | | | | | DRJ DRJ | VE, | | ASHINGTO | | |
| altimore, mit. Pages 1 ar | important: it tem 27 any injury or other tr once. | 20a. Method of Disposition 1 Burial 2 Cremetion 4 Donation 5 Other (Sp | | State | lece of Dispo emetery, cred RYLAND | metory or oth | ner ple | | | Dete | 20c. Location - (| | maryland |
| Baltim parmit. Pag Department | injur. | 21. Signifure of Funeral Service L | | THAI. | 22 | . Name and | Addre | ss of Facili | ity | | | TENT, | TANTIAND |
| Depart | o do | Audia Co | MION JOH | NISON MOO | Theres | HORNTO | N F | UNERA | T HO | ME, P. | | MD | 20640 |
| | | 23a. Part1. Enter the disease, or a shock, or heart failure. List of | | | | | | | | | | , 110 | Approximate |
| Phys | ician | snock, or near failure. List o | | ~ | | | | | | ^ | | 1 | Onset end Death |
| | dical | Immediate Cause (Final | | GVC | Pisa | Jula | - | Nov | ~ | AV | 0,1 | | |
| Exan | niner | disease or condition resulting in death) | A | Due to (or | 1.9/ | Allegeres a | | | - | 1/1/ | 91 | 1 | |
| | ē . | | To | Due to (or | res a comun | wence of): | -1. | . 40 | / | 4 | | 1 | |
| De la | T P | | b. 0 | Jerc | | | | 0 /01 | 20/ | para | 7 | 1 | |
| ox 68/60, certificate be executed | burial-transit | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | 1.1 | Due to (or | r as a conseq | uence of): | | | | , | , | 1 | |
| 68/60 ficata be a | | Cause (Disease or injury that initiated events | c. + | Sper | Le | 75 | 7 (| ~ | | | | - | |
| O at a | s the bu | resulting in death) Last | | O Due to (or | r as a conseq | uence of): | | | | | | 1 | |
| Sentifi X | S & | | d | | | | | | | | | | |
| n a | for use as | | | | 20 | | | | | | | | |
| . 0 | etached for us Physician/ | Part It. Other algnificant condition | | | | | | 4 | | | tobacco una con | tribute to | the cause of death? |
| ecords, P.O. | be detached by Physic | Mutiple | Cere | 800 V | 'as a | eler | f | tcc. | do | £ 10 | Yea 2□ No | 3 Prol | bably 4 Unknown |
| Records, | 200 | | | | | | | | | | s an autopsy | 24b. W | era autopsy findings |
| 0 2 3 | should | | | | | | | | | perl | ormed? | CO | ailable prior to mpletion of ceuse |
| | irector, page 2 should be Be Completed | | | | | | | | | | | Of | death? |
| = = = | ga o | | | | | | | | | 10 | Yes 2X No | 10 | Yes 2 No |
| Of VICAL Physician: T | director, | 25. Was cese referred to medical axaminer? | 11 22 | | | | 1 | | e of Deat | h (Check only | one) | | |
| Physic Physics | | 1 ☐ Yes 2 ☐ No | Hospital: | Inpatient 2 | ER/Outpatier | t 3□ DO/ | Of | ner: 4 N | ursing Ho | | idence 6 Othe | . , . | y) |
| | the funeral | 27. Manner of Deeth 1 DNaturai 5 ☐ Pending | 28a. Date (Mon | of fnjury oth, Day Year) | 28b. Time of fnjury | 28 | c. fnju | rk? | | 28d. Describe | how injury occurre | ed | |
| Tag : | he fu | 2 Accident investiga | ation | | | М | 1 🗆 | Yes 2 | No | | | | |
| LIVISION I or Attending after death. | 3 > = | 3 Suicide 6 Could no determine | and 286. Plece | of Injury - At ho ing, etc. (Specify | me, ferm, str | eet, factory, | office | | - 2 | 28f. Location City or To | (Street end Number wn, Stele) | er or Rura | al Route Number, |
| To the Hospital or A within 24 hours after To the Funeral Direct | completely filled | 29a. Certifier 1 Certifying | Physician: To the | haet of multi- | uladaa dash | nonurred - | the st | me dete | ad plans | and due to the | anunala) and an | 2005 22 - | totad |
| Hose 24 h | oletely fi | | xaminer: On the b | asis of examination states. | ion and/or inv | estigation, i | n my c | pinion, dea | ath occur | red at the time | dete and place, a | and due to | the cause(s) |
| ithin th | Me Me | 29b. Signeture and title of certifier | / | | | 29c. | Licens | se number | | | 29d. Date signed | (Month. | Day, Year) |
| F 3 F | - 0 | 1/ | | -4 | _ | - | N | 2 4 | 5 | 23 | il | , - | 100 |
| | | | / | 1 - | | | D | 77 | | - / | 11 | 1) | 100 |
| | | 30. Name and address of person w | / | se of death (Item | 1 | Print) | 0. | 1 < | 1. | al f | - Washing A | / | 10 2-2111 |
| | | 01.00101a 05 | buawa | 11101 | | 795 for | MA | a du | 140 | that had | - www.ngf | The ! | W 20144 |
| | State | 31. Dete filed (Month, Dey, Year) | 2000 32. R | legistrer's Signat | ture 4 | 1 | | 1, | | | | | |
| H | egistrar | JANIA | 71/11/1 | The same of the sa | N. | 100 | aca | 0 | | | | | |



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| | | | | Ce | rtifica | te of | Death | | Re | ig. No. | J | 6613 |
|--|---|--|---|---|----------------------------------|-----------|-----------------------------------|-----------------------|--|---------------------------|-------------------------------------|--|
| DI | 1. Decedent's Name (First, Middle, | | | | | | | | 2. Date of Deat Month | h Day | Year | 3. Time of Death |
| Physician /Medical | Mary | in David | d Gro | gg | | 1.0 | | | 1 | 9 | 00 | DAM |
| Examiner | 4e Facility Name (If not institution, Carroll County (| | | 1 | | | West | mins | ter | 4c. County Car | of Death | |
| Funeral Director | 233-70-0425 | 3. Sex 1 M 2 □ F | . Age (In yrs. 57 | last birthday) Yrs. | Months | Days | If Under Hours | 24 Hrs. Min. | 8. Date of Birth (Month, Day, NOV 6, | 1942 | 9. Births Cour | place (State or Foreigntry) |
| | Usuel Residence of Decedent 10e. Stele 10b. County | | 10c Ci | ity, Town or Lo | nestion | _ | | | | | 1 | Od. Inside City Limits |
| or 28a-f sho be notified at Director | MD Carro | 011 | 100.0 | | stmin | | | | | | | 1 ☐ Yes X☐ No |
| | 3400 Nottingham | Road | | | 10f. Zi | p Code | 21157 | | 10 | og. Citizen of USA | | ntry? |
| Examina by Fu | 11. Marital Status 1 □ Never Married 2 ☑ Merried 3 □ Widowed 4 □ Divorced | 12. Wes Deced Armed Ford 1 Yes 2 If Yes, Give Yeer or Dat | es? Mag No | J,S. 13. | Was Dece If Yes, spi 1 Yes | | lispanic Origan, Mexican Specify: | gin? (Sp i, Puerto | ecify Yes or No- Rican, etc.) | | ce - Americ ck, White, by: Wh | |
| fical fical | 15. Decedent's (Specify only highest | | | 16a. Dece | dent's Usu | al Occup | ation during most | t of work | ina | 16b. Kind of B | lusiness/In | dustry |
| c. the Medical | Elementary/Secondery (0-12) | College (1-4 | for 5+) | | | | during most d) e Eng: | | | Bake | ry | |
| | 17. Father's Neme (First, Middle, La | ist) | | | | | 18. Mothe | r's Name | e (First, Middle, N | faiden Sumar | ne) | |
| To | Forrest Ernes | st Grogg | | | | | Flo | ora l | Mae Shee | ts | | |
| | 19e. Informent's Neme/Reletionship | (Type, Print) | | | | | | | al Route Number | | | |
| 5 | Mrs. Barbara Jea | an Grogg (| Wife) | 3400 | Nott | ingh | am Roa | ad W | estminst | er, MD | 2115 | 57 |
| ury or oth | 20a. Method of Disposition 1X Burial 2 Cremetion 3 4 Donation 5 Other (Spe | | ala. | Place of Dispondence | metory or | other ple | | rk 1 | Date /12/2000 | Sykes | | |
| any inj | 21. Signature of Funeral Service Lie | X. Hai | gut | | | | | | E & CHAP 84 (410) | | | 5) |
| iclan dical niner | 23a. Pert1. Enter the disease, or conshock, or heart feiture. List or Immediate Ceuse (Final disease or condition resulting in deeth) | nly one cause on ea | ARCI | or as a conse | ATO | 051 | | Carolac | or respiratory arre | 331, | 1 | Approximate Interval Between Onset and Death |
| edical Examiner | Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events | b/\ldots c | Due to (| or as a consec | quence of) | : | . C/ | 9RC | Nome | | | ** |
| 3 | resulting in death) Lest | d | Due to (t | or es a consec | querice or, | | | | | | | |
| d for use | Part II. Other significant conditions | contributing to dea | th but not res | sulting in the u | ınderlyina | rausa ni | van in Part t | | 23h Did to | hacco usa co | ontribute to | o the cause of death |
| be detached for use by Physician/ | VANCOMYC | | | NT G | | | | | 1 🗆 Ye | | | bebly 4 Unknow |
| should | Wour | DINFE | CTION | J | -16 | | | | 24a. Was a pertorn | | av | ere autopsy findings allable prior to impletion of cause death? |
| page 2 | | | | | | | | | 1 □ Ye | s 200 No | 1[| Yes 2□ No |
| certificate rector, pay | 25. Wes case referred to medical | | | | | | 26. Place | of Daet | h (Check only on | 9) | | |
| | examiner? 1 ☐ Yes 2 ☐ No | Hospitel: | patient 2 | ER/Outpatie | nt 3□ D | OA Ott | 100 | | me 5 Reside | | her (Specil | (v) |
| 2 - | 27. Menner of Death 1 DNetural 5 Pending 2 Accident Investige | 28a. Dele of (Month, | | 28b. Time o Injury | | 28c. Inju | | | 28d. Describe ho | | | ,, |
| o the Funeral Director: After a completely filled in by the funeral Medical Certification: | 3 Suicide 6 Could no delemina | 288. Place 0 | f Injury - At h , etc. <i>(Speci</i> | ome, ferm, str | reet, facto | y, office | | | 28f. Location (St City or Town | reet and Num. , State) | ber or Run | al Route Number, |
| pletely fille | | Physician: To the base and menne | is of examine | | | | | | | | | |
| Ne Me | 29b. Signeture end title of certifier | / | | | 29 | c. Licens | se number | | 2 | 9d. Date signe | ed (Month, | Day, Year) |
| 0 | thread | 18/2 | -05- | - & m | 2 | | 0 166 | | | 119 | 100 | 100 |
| | 30. Name and address of person who VINCENT I. | FIDER | o Ja | | Print) | | | | TER P | | 2115 | 7 |
| State | 31. Date filed (Month, Dey, Year) | 2000 32. Reg | istrar's Sign | eture 4 | | 1 | | | | | | |



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| | Ī | Decedent's Name (First, Middle, | Last) | 11.00 | 001 | tificate of | Doutif | 2. Date of De | Reg. No. ath | | 3. Tima of Death |
|---|-----|--|---|-------------------|----------------------------|---|--|---|--------------------------------------|-----------------------------|---|
| ysician | | Dorothy | 4. | Gibbs | 3 | | | Month | Day | Yaar 2000 | 0725 |
| Medicat aminer | | a. Facility Name (If not institution, | give street and nur | m <i>ber)</i> | | | 4b. City, Town, o | Januar Location of Death | | | 0100 |
| 0,5 | ı | Union Hospita | 1 | | | | Elkton | | Ce | cil | |
| eral ter | | 214-24-1422 | S. Sex 1□ M 2只F | | last birthday). Yrs. | If Under 1 Yea Months Days | | | y Yaar) 1927 | 9. Birthpl Count E1Kt | ace (Stata or Foreign On , MD . |
| | - | Usual Residence of Decedent 10a. Stata 10b. County | | 10c. C | ity, Town or Loc | cation | | | | 10 | Od. Inside City Limits |
| ŏ | | MD Ceci: | L | | kton | | | | | | 1 ☐ Yas 2 ☐ No |
| Funeral Director | , | 10e. Street and Number 303 Knights (| Corner I | | | 10f. Zip Code | 21921 | | 10g. Citizen of V USA | Whet Count | ry? |
| by | | 11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced | | 21 No | | Vas Decedent of Yes, specify Cu | | (Specify Yes or No orto Rican, etc.) | 14. Rac Blac Specify | e - America ck, Whita, a | |
| Completed | | 15. Decedant's (Specify only highest Elemantary/Secondary (0-12) 11th | grade compieted) College (1 | -4or 5+) / A | life. D | ent's Usual Occi kind of work don OO NOT usa retir | upation a during most of и ed) | rorking | 16b. KInd of Bu | | |
| To Be | | 7. Fathar's Name (First, Middla, L. Arthur Gibbs | | ased) | | | | ame (First, Middle, Scott | | | |
| | | 19a. Informant's Name/Relationshi | p (Type, Print) | 100 | 19b. Mailin | g Address (Stree | et and Number or | Rural Route Numbe | er, City or Town, | Stata, Zip | Code) |
| | 2 | Thelma Brool Coa. Mathod of Disposition The Burlal 2 Cremation All Donation 5 Other (Spe | | | Place of Dispos | 3 Knigl Sition (Nama of Patory or other pi Manor | | ner Rd Date | 20c. Location - | City or Tov | |
| once. | - | 21. Signature of Funeral Sarvica LI | | | | Name and Add | Smith. | - | HIGH | | |
| as the bunet-transit and a least the confidence of the confidence | i i | Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, ff any, leading to immediate causa. Entar Underlying Causa (Disease or injury hat initiated avants resulting in death) Last | b. Pe | fordt Dua to (| in Sulfor as a consequence | Bower juance ot): | - (+10 | | | | 7 days 3 days 2 yes |
| by Physician/M | F | Part II. Other significant condition | - | | sulting in the un | | iven In Part I. | | V | ntribute to | the causs of deeth? |
| Completed | - | | | | | | | 24a. Was perlo | an autopsy med? | ava | re autopsy tindings llable prior to apletion of causa leath? |
| Fo Be Com | | | | | | | | 101 | ras X No | 10 | Yas 2 No |
| Be | 2 | 25. Was cese reterred to medical examinar? | Hospital: | | | | | eath (Check only o | ne) | | |
| | 2 | 1 Yes 2 No | 28a. Data | | ER/Outpatient | 3LI DUA | | Home 5 Resid | dence 6 Oth | |) |
| Medical Certification: | | 1 Natural 5 Pending investiga 3 Suicide 4 Homicide | tion (Mont | h, Day Year) | Injury ome, farm, stre | M 1 [| Yas 2□No | | Street and Numb | | Route Number, |
| Medical Cel | 2 | 29a. Certifier 1 Certifying (Check only one) | Phyaician: To the aminer: On the ba and man | sls of examina | owledge, death | occurrad at that | ime, date and pla opinion, daath oc | ca, and due to the courred at the tima, | cause(s) and ma data and place, a | nner as sta | ated. the cause(s) |
| M | 2 | 19b. Signatura and title of certifier Fur clui | | | | | se number PB23 | | 29d. Date signe | | 21921 |
| | | 0. Nama and address of person wi | | | | | | | - | _/ | |

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State of Maryland / Department of Health and Mental Hygiene 0 2275

| | | | C | ertificat | e of | Death | | Re | g. No. |) () | Con Cons I V |
|---|--|---|---|---------------------------------|-----------------------|---------------------------------------|-----------------|---|---------------------------|-----------------------------|--|
| | 1. Decedent's Neme (First, Middle, L | ast) | | | | | | 2. Dete of Deat Month | h Day | Year | 3. Tima of Death |
| Physician /Medical | Bruce Ivan | Green | | | | | | Janua | | .2000 | 12:30 P. |
| Examiner | 4a Fecility Name (If not institution, g | ive street and number) | | | | 4b. City, To | wn, or Lo | ocation of Death | 10 | ty of Death | |
| | Anne Arundel Me | edical Cent | er | | P | nnapo | olis | | Anne . | Arund | e1 |
| Funeral | 5. Social Security Number 6. | 7770 | e (In yrs. last birthd | Months | | If Under Hours | 24 Hrs. Min. | 8. Date of Birth | Year) | 9. Births | place (State or Foreigntry) |
| Director | 479-10-4592 Usuel Residence of Decedent | XXM 2□F | 85 Yrs | 3. | Days | Tiours | | July 6, | 1914 | Low | a |
| anytar ahow aff at | 10a. State 10b. County | | 10c. City, Town o | r Location | | | | | | 1 | I Od. Inside City Limits |
| r 28a-f show Lostfied at Irector | Maryland Anne | e Arundel | | Edge | wate | er | | | | | 1 □ Yes 2 No |
| or zile-f. be notifie Directo | 10e. Street and Number | | | 10f. Zip | | | | 10 | og. Citizen of | | ntry? |
| | 157 Duval Lane | | | 2 | 1037 | 7 | | | US | A | |
| hours after death with I ural, or itsens 23a or 3 al Examiner must be n ed by Funeral Dir | 11. Marital Status 1 Never Merried 2 Merried 3 Widowed 4 Divorced | 12. Wes Decedent E Armed Forces? 1 Yes 27 N If Yes, Give A Year or Dates: | Ever in U,S. | 3. Was Deced If Yes, spec | | lispanic Or an, Mexica Specify: | | ecify Yes or No- Rican, etc.) | | ice - Americ eck, White, | |
| 72 ho Martur Martin | 15. Decedent's I | | 16a. De | cedent's Usua | al Occup | ation | | | 16b. Kind of E | Business/In | dustry |
| ed within 72 ho ygiens. we then "natur it, the Medical. Completed | (Specify only highest g Elementary/Secondary (0-12) | rade completed) College (1-4or 5 | lil. | ive kind of wor e. DO NOT us | rk done se retired | during mos 1) | t of work | ing | | | |
| Daniel Paris | Cromonary/Socordary (0-12) | 2 yrs. | * | Engin | eer | | | | Elec | trica | 1 |
| SIES O | 17. Father's Neme (First, Middle, Las | 1) | | | | 18. Moth | er's Name | (First, Middle, A | faiden Sume | me) | |
| | Edward | Earl Gree | n | | | (| Gerti | cude Cli | ng | | |
| 45EE | 19a. tnforment's Neme/Reletionship | (Type, Print) | 19b. M | eiling Address | (Street | and Numb | er or Run | ni Route Number, | City or Town | n. Stete. Zic | Code) |
| N = # 8 | Helen K. Green/ | | | | | | | er, Mar | | | |
| s 1 and 2 at the Health av (Health av Other trau | 20a. Method of Disposition | MITE | 20b. Plece of Di | sposition (Nen | ne of | | gewat | | y Lanu 20c. Location | | |
| Pages ment of ant: If la | 1 Burial 2 Cremetion 3 4 Donation 5 Other (Spec | | Lakemor | | 1. (| Garden | | 1-17-00 | Davids | | |
| Depart Import any in | 21. Signature of Funeral Service Lice | M1000 | | 22. Neme an George | d Addre | ss ot Fecili Kalas | Fun | eral Ho | ne | | |
| | 23a. Part1. Enter the disease, or co | | | 2973 S | olon | ons] | slan | d Rd. Ed | lgewate | er, M | D 21037 Approximate |
| Physician /Medical Examiner | shock, or heert feilure. List onl Immediete Cause (Final disease or condition resulting in death) | a | PNEVI Due to (or as a con | | 9 | | | | | 9 1 1 3 6 | Interval Between Onset and Death |
| The law requires that the death certificate be associted the has been signed by the attending physician and page 2 should be detached for use as the burial-transit completed by Physician/Medical Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Couse (Disease or injury that initiated events resulting in death) Last | c | Due to (or es e con | | | | | | | | |
| atte difor | Dat II Other significant and distant | | A A 1 - 4A | | | D. | | l con Dida | | 1 | - 11 - 1 - 1 |
| res that the death or bigned by the attend the detached for us by Physician/ | Pert II. Other significant conditions | Viestive | | | | | | | s 2 No | | o the cause of deati bably 40 Unkno |
| The law requires trate has been signe page 2 should be d | | 'AL. | | | | | | 24a. Was a perform | n autopsy ned? | av co | ere autopsy findings allable prior to empletion ot cause death? |
| The la | | | | | | | | 1 □ Ye | s 2000 | 11 | ☐Yes 2☐ No |
| certificate rector, pag | 25. Wes case referred to medical | | | | | 26. Place | of Death | h (Check only on | 9) | | |
| Physician: rthis certific rtal director. TO Be (| examiner? | Hospitel: 1 Impatier | nt 2 ER/Outpa | tient 3 DC | A Oth | er: 4 🗆 Ni | irsina Ho | me 5 Reside | nce 6 🗆 Ot | ther (Specia | (v) |
| B 55 0 | 27. Manner of Death 1 Neturat 5 Pending 27 Accident investigeti | 28a. Dete of Injur (Month, Day | | | 8c. Injur Wor | | | 28d. Describe ho | | | ,, |
| To the Hospital or Attanding P within 24 hours after death. To the Funeral Director: After completely filled in by the funeral Medical Certification: | 2 Accident Investigets 3 Suicide 6 Could not determined | De Disco of lain | ry - At home, ferm, . (Specify) | | | | | 28f. Location (St. City or Town | reet and Num , State) | iber or Rurr | al Route Number, |
| he Hospita in 24 hours he Funeral pletsly filled edical C | 29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa | hysician: To the best o | f my knowledge, de examinetion end/o | eath occurred a rinvestigation, | at the tir in my o | ne, date ar pinion, des | nd place, a | and due to the ca ed et the time, da | use(s) and mate and piece | nanner as a | stated. the cause(s) |
| within To the comple | 29b. Signature and title of certifier | Stee | fell | 1 | 00 | | | (| | 14, | 2000 |
| | 30. Name and address of person who | | eath (Item 23a) (Ty | pe, Print) | 5111 | 131 | Sine | SHADY | 1 510 | 20 | 12D |
| State Registrar | 31. Date filed (Month, Day, Year) | 2000 32. Registre | r's Signeture | 6. 1 | 600 | de | | | | | |

prom B. Herry

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month JENNIE NAOMI HUGHES 9 2000 0449 JAN 4e. Facility Neme (If not Institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth DORCHESTER GENERAL HOSPITAL CAMBRIDGE DORCHESTER 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Deys Hours Min. 7. Age (In yrs. last birthdey) 8. Dete of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) Deys 1□M 2\ F Yrs. 213-22-8718 91 JAN. 6, 1909 MARYLAND Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 N Yes 2 No MARYLAND DORCHESTER VIENNA 10e. Street end Number 10f. Zip Code 10g. Citizen of Whef Country? 405 OCEAN GATEWAY 21869 USA 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 11. Meritel Stetus 1 ☐ Yes 2 🔀 No If Yes, Give Yeer or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: WHITE 3 XWidowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondery (0-12) College (1-4or 5+) NURSING ASSISTANT STATE HOSPITAL 10 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) ELIJAH HUGHES JENNIE SPENCER 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) VERNON E. HUGHES/SON P. O. BOX 215, VIENNA, MARYLAND 21869 20b. Placa of Disposition (Neme of cametery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 XBuriel 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) EAST NEW MARKET CEMETERY 1/11/00 EAST NEW MARKET, MD 21. Signature of Faneral Service Lie ZELLER FUNERAL HOME, P. O. BOX 207 106 MAIN STREET, EAST NEW MARKET, MD 21631 of mplications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, the contract of the cause on each line. Approximate Intervel Between Immediate Ceuse (Finel diseese or condition resulting in deeth) Vehicle Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initialed events resulting In deeth) Lest Due to (or es e consequenca of): Due to (or es a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24e. Wes an eutopsy performed? 24b. Were eutopsy findings avelleble prior to completion of cause of deeth? 25. Wes case referred to medical 28. Plece of Death (Check only one) Hospitel: 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending investigation 1 Neturel Mutor Vehicle Accident 736 PM 1 Yes 2 AND **Accident** JANZ 2000 8 Could not be determined 3 ☐ Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

RT 16 Doz . Co Md 281. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide Dorchster CO

P.O. Box 68760. Records, of Vital Division

sician and buriel-transit The law requires that the death certificate be executed physician s the burie signed t director, page 2 should or Attending Physician: this funeral After deeth. efter deeti in by t Hospital 24 hours within 24 hor To the Fune completely fi To the

Physician

/Medicai

Examiner

Funeral

Director

28a-f show

b Herns 23a

'natural', or

marked

Important: If Item 27 is m any injury or other traum once.

Physician /Medical

Examiner

Physician/Medical Examiner

þ

Completed

Be

2

Certification:

edicai

29a. Certifier

21215-0020

Baltimore, Maryland

Pages 1 and 2 should be nent of Health and Mental

Director

Funeral

þ

Completed

Be

29b. Signature end title of certifie

Dor. Co Md.

1 Certifying Phyeician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner es stated.

Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete end pieca, end due to the ceuse(s) end menner stated.

29c. License number

29d. Dete signed (Month, Day, Yeer)

30 Name and address of person who completed ceuse of deeth (Item 23a) (Type, Print) Faller AS 302 CULLIES 11ch ne

Hurlock MO21643

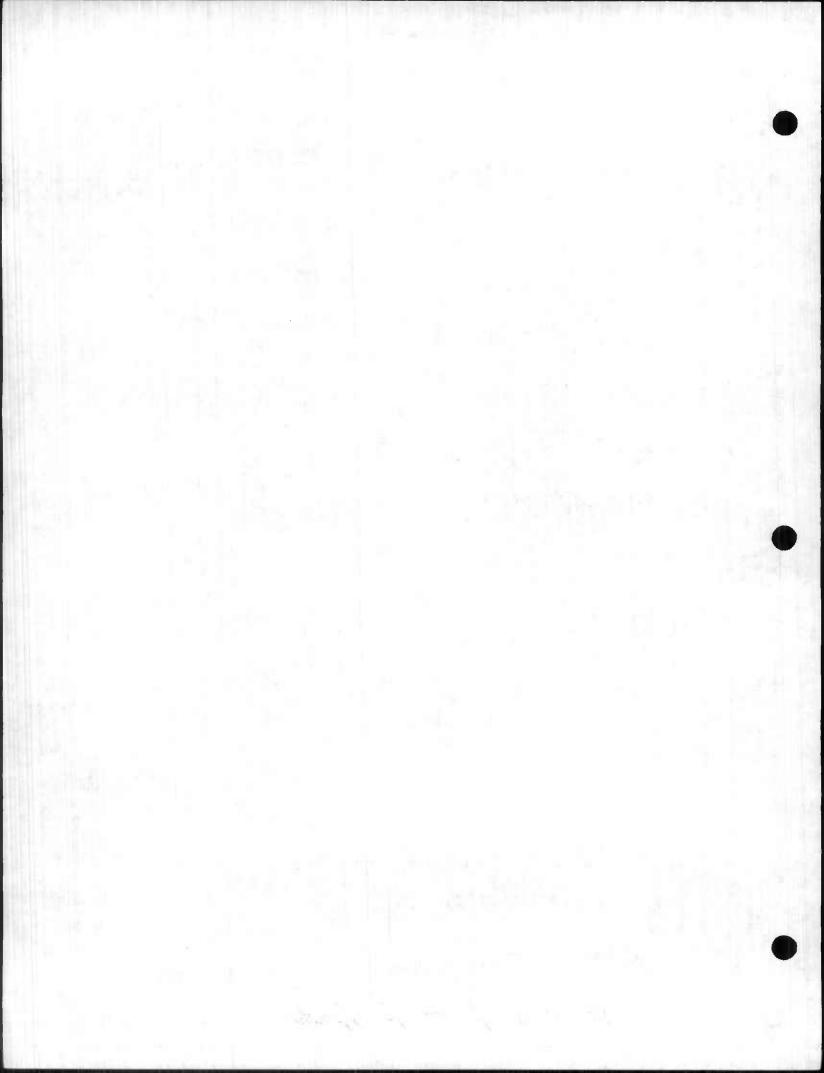
State Registrar 31. Dete filed (Month, Day, Yeer) JAN 18 2000



to the second of
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State of Maryland / Department of Health and Mental Hygiene

| | Hill AMEND ITEMS: #23 PART I, 27 Certificate of | 2. Dete of Death Month | Dev Year 3. Time of Death |
|--|---|---|---|
| Physician /Medical | Victoria M. Hill | January | 17, 2000 6:25AM |
| Examiner | 4e Facility Neme (If not institution, give street and number) | 4b. City, Town, or Location of Deeth Sykesville | 4c. County of Deeth |
| *Funeral | Springfield Hospital 5. Social Security Number 5. Social Security Number 1 | r If Under 24 Hrs. 8. Dete of Birth | Carroll 9. Birthplace (State or Foreign Country) Washington, DC |
| Director | Usuel Residence of Decedent | Mar 13, | 1944 Washington, DC |
| yland | 10a. State 10b. County 10c. City, Town or Location | | 10d. Inside City Limits |
| or 28a4 s be notified Director | MD Montgomery Bethesda | | 1 X Yes 2 □ No |
| | | 0824 | J. Citizen of What Country? USA |
| hours after death unel; or Heme 23 at Examiner must be by Funeral | 11. Men'tel Stetus 1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Wes Decedent Ever in U,S. Armed Forces? 1 Yes, Give Yeer or Detes: | Hispenic Orlgin? (Specify Yes or No- ben, Mexicen, Puerto Rican, etc.) Specify: | 14. Race - American Indian, Bleck, White, etc. Specify: White |
| matu dical | 15. Decedent's Education 16a. Decedent's Usuel Occi (Specify only highest grede completed) (Give kind of work don | upation 16 e during most of working ed) | b. Kind of Business/Industry |
| ed within 72 ho ygiens. wr then "naturn I, the Medical. Completed | Elementery/Secondary (0-12) College (1-4or 5+) Homemake | | Domestic |
| tal Hyginal Hy | 17. Father's Neme (First, Middle, Last) | 18. Mother's Neme (First, Middle, Ma | |
| Vienta Vienta Vice Vice Vice Vice Vice Vice Vice Vice | Charles E. Mahau, III | Helen Ida Mar | rtindale |
| and 2 sho salth and 127 is ma er traums | | et end Number or Rurel Route Number, of y Drive, Philadelph | |
| Pages 1 ment of He ant: If her ury or oth | 20a. Method of Disposition 1 Buriel All Cremetion 3 Removal Irom Stete 4 Donation 5 Other (Specify) 20b. Place of Disposition (Neme of cemetery, cremetory or other place) All County Crema | tion Serv.1/21/200 | oc. Location - City or Town, State O Sykesville, MD |
| Departi Departi Import any inj ance | | ress of Facility NERAL HOME & CHAPE e, MD 21784 (410)- | |
| | 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dy shock, or heart leiture. List only one cause on each line. | ring, such es cerdiac or respiretory erres | t, Approximate Interval Between |
| Physician /Medical | Immediate Cause (Fine) HVPFRTFNCTVF ATHER | OCCI EDOTTO CARRIOTO | Onset end Death |
| Examiner | resulting in deeth) | ROSCLEROTIC CARDIOV | ASCULAR DISEASE |
| je men | Due to (or as a consequence of): | | |
| tate be executed whysician and the burial-transit dical Examiner | Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying | | |
| 5 5 E | Causa (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): | | |
| that the death certified by the attending detached for use a Physician/M. | | | |
| 0 0 0 | Part II. Other significant conditions contributing to death but not resulting in the underlying cause g | | acco use contributa to the causs of death |
| 5 50 > | RENAL CELL CARCINOMA | - C TSS | 2 No 3 Probably 4 Dolland |
| been s should should | | 24a. Was an performe | autopsy ed? 24b. Were eutopay findings available prior to completion of cause of death? |
| The law ate has page 2 | | fe/res | 2 No 1 Yes 2 No |
| ystclan: The is certificate director, pag | 25. Was case referred to medical axeminer? | 26. Place of Death (Check only one) |) |
| 2 00 | Hospitel: 1 □ Inpatient 3 □ DOA □ | ther: 4 Nursing Home 5 Residen | ce 6 ☐Other (Specify) |
| Attending Ph r death. betor: After thi by the funeral iffication: 1 | 2 Accident | ury at ork? ☐ Yes 2 ☐ No | rinjury occurred |
| tal or Attending P rs after death. al Director: After t led in by the funera Certification: | 3 Sulcide 6 Could not be determined 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) | e 28f. Location (Stre City or Town, | et end Number or Rurel Route Number, Stete) |
| in 24 hours he Funer pletely fill edical | 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deeth occurred et the position on the basis of examination and/or investigation, in my and menner steted. | opinion, deeth occurred at the time, date | e and place, and due to the cause(s) |
| To with | () | | d. Dete signed (Month, Dey, Year) |
| | my me | .M.E. Ja | anuary 21, 2000 |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn St 31. Date filled (Month, Day, Year) 32. Registrer's Signature | treet, Baltimore, N | Maryland 21201 |
| State | A HOUSTON STORY TOWN TOWN | | |



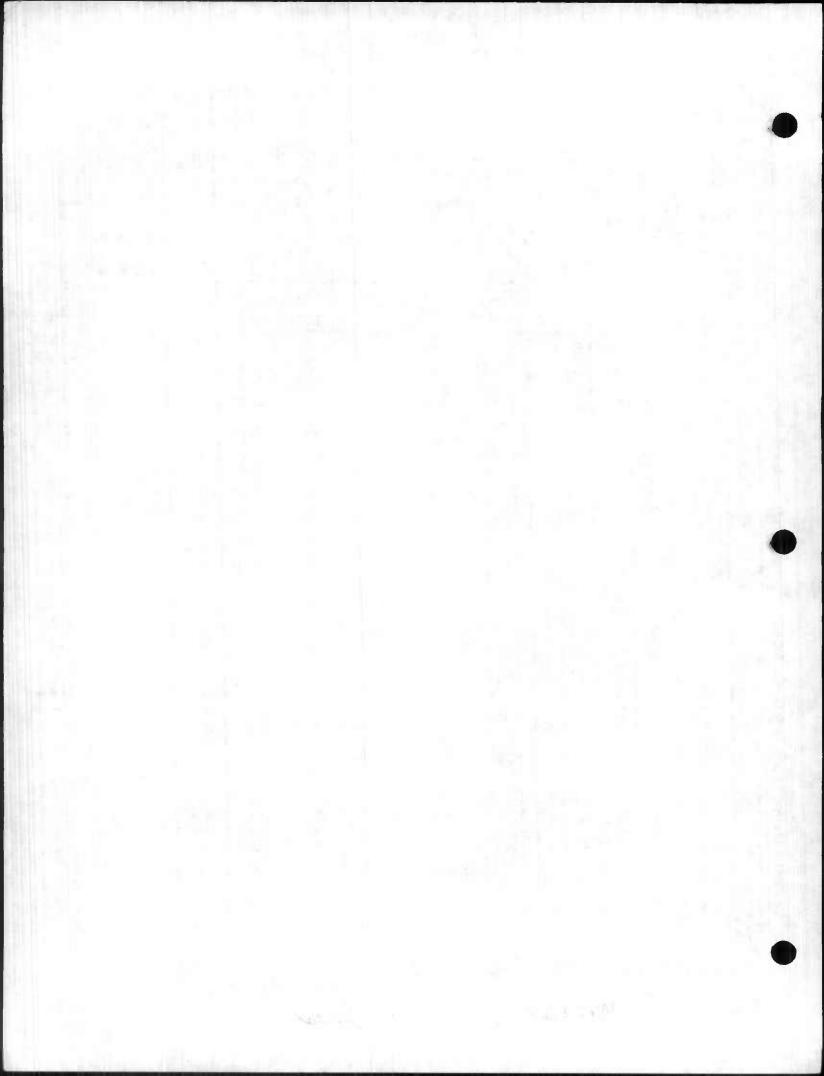
Please Type or Print in Black Indelible Ink. Assure Ail Copies Are Legibie.

| 1. Decedent's Nama (First, Middle, Las | 28A-F PER MEO | Certific | Winds. | | 2. Date of De | | 3. Tima of Death |
|--|--|---|--|--|---|--|--|
| G | ARY STEVEN H | ARRIS | | | JAN. | Day 22, 20 | 00 10:05 AM |
| 4a Fscility Name (If not institution, give | street and number) | | | 4b. City, Town, o | Location of Deat | | |
| | | | | | | | ROLL |
| 1 | | Mor | | | 8. Date of Bi | rth ay, Year) | 9. Birthplace (State or Foreign Country) MARYLAND |
| Usual Residence of Decedent | 12 | | | | 8/20/ | 1957 | MARYLAND |
| 10a. Stata 10b. County | 10c. City | Town or Location | 1 | | | | 10d. Inside City Limits |
| MD. CARROL | L W | ESTMINS | STER | 14 4 4 | | | 1X Yes 2 No |
| | | 10 | | | | | Vhat Country? |
| | | 13 Was F | | | Specify Yes or No | | e - American Indian, |
| 1 Never Merried 2 Married | Armed Forces? | | | | rto Ricen, etc.) | Blac | ck, White, etc. |
| 3 ☐ Widowed 4 ☑ Divorced | If Yes, Give ** Yeer or Dates: | 1 U Y | es 2XNo | Specify: | | Specify | WHITE |
| 15. Decedent's Ed | | (Give kind o | of work done | during most of w | orking | 16b. Kind of Bu | usiness/Industry |
| Elementary/Secondary (0-12) | College (1-4or 5+) | life. DO No | | | | 20112 | |
| 17. Father's Name (First, Middle, Last) | | | MA | 1 | ame (First, Middle | | |
| | JOSEPH HARR | IS, SR | | | | | |
| 19a, Informant's Neme/Relationship (7 | | | | t and Number or F | Rural Route Numb | per, City or Town, | State, Zip Code) |
| | IS, SR. | | | STER RE | .,WEST | MINSTER | R, MD.21157 |
| 20a. Method of Disposition 1 ☑ Burlal 2 ☐ Cremation 3 ☐ | Demousi from State Ce | metery, crematory | or other pla | | Date | | City or Town, Stata |
| 4 Donation 5 Other (Specify | MEA | | | | /26/00 | WESTMI | NSTER, MD. |
| 21. Signatura of Funeral Service Licen | 14- A | | | L | | | |
| Thomas of 12 | LA. | | | | - | | |
| shock, or heart failure. List only | one cause on each line. | . Do not enter the | mode of dyl | ng, such as cerdi | ac or respiratory a | arrest, | Approximata Interval Between Onset and Death |
| Immediate Cause (Finel | NARCOT | TC AND A | LCOHOI | TNTOXIO | CATTON | | |
| resulting in death) | 8. | 7000000 | | | 0.12 2.011 | | 1 |
| | h | | | | | | |
| Sequentially list conditions, | Due to (or | as a consequence | e of): | | | | |
| Cause (Disease or Injury | c | | | | | | |
| rasulting in death) Last | Due to (or | as a consequence | e of): | | | | |
| | d | | | | | | |
| Part II. Other significant conditions co | entributing to death but not resul | iting in the underly | ring ceuse gi | ven in Pert i. | 23b. Did | tobacco uss co | ntributs to the cause of death? |
| | | | | | 1 | Yes 2 No | 3 Probably 49 Unknown |
| | | | | | | | I |
| | | | | | | s en eutopsy ormed? | 24b. Wera autopsy findings available prior to completion of ceuse |
| The second second second | | | | | 31 L | | of death? |
| 750 | | | | | | | 1 Types 2 No |
| 25 Was case relayed to - affect | | | | 00.01- | | Yes 2 No | 13.100 22.110 |
| 25. Was case referred to medical examiner? | Hospital: 1 □ Inpatient 2 □ F | -B/Outpatient 3 | DOA Ot | her | eath (Check only | one) | |
| examiner? Yes 2 No 27. Manner of Death | 28a. Date of Injury | ER/Outpatient 3E 28b. Time of A | J DOA | her: 4 Nursing | eath (Check only Homa 5XX)Res | | er (Specify) |
| examiner? 27. Manner of Death 1 Netural 5 Pending invastigation | 28a. Date of Injury FO(Manh, Day Year) 1-21-2000 | | 28c. Inju | her: 4 Nursing | eath (Check only Homa 5XX)Res | one) idence 6 Oth | er (Specify) |
| examiner? Yes 2 No 27. Manner of Death 1 Netural 5 Pending | 28a. Date of Injury FO Month, Day Year) 1-21-2000 28a. Place of Injury - At hor | FOUND: A TO:15 To:15 To:15 To:15 | 28c. Inju | her: 4 Nursing iny at ink? | Homa 5XX Res 28d. Describe | one) idence 6 Oth how injury occur WN | er (Specify) red |
| examiner? YES 2 No 27. Manner of Death 1 Netural 5 Pending invastigation 3 Suicide 6 Could not be determined | 28a. Date of Injury FO(Mark). Day Year) 1-21-2000 28e. Plece of Injury. At hor building at (Specify) | POUND: M FOUND: M 10:15 ne, farm, street, fa | 28c. Inju | her: 4□ Nursing iry at rk?] Yes 🌂 No | eath (Check only Homa 577 Res 28d. Describe UNKNO 281. Location City or To | one) idence 6 Oth how injury occur WN (Street and Numb wn, State) 150 RG, MD | er (Specify) red per or Bural Boute Number. 3 W.LIBERTY RD. |
| examiner? 1 Netural 2 Accident 3 Suicide 4 Homicida 29a. Certifier (Check only 1 Certifying Phy (Check only 1 Certifying Phy (Check only 2 Medical Exam | 28a. Date of Injury FO (1871). Day Year) 1-21-2000 28e. Plece of Injury - At hor building els. (Specify) FOUND ACT | 28b. Time of A FOUND: M 10:15 ne, farm, street, fa RESIDENC | 28c. Inju | her: 4 Nursing ry at rk? Yes 1 No | Homa 5XMes 28d. Describe UNKNO 281. Location City or 7c | one) idence 6 Oth how injury occur WN (Street and Numb iwn, State) 150 RG, MD | per of Bural Boute Number. S W. LIBERTY RD. |
| examiner? Yes 2 No 27. Manner of Death 1 Netural 2 Accident 3 Suicide 4 Homicida 29e Certifier 1 Certified Physics | 28a. Date of Injury FO(N) Day Year) 1-21-2000 28e. Plece of Injury · At hor building at (Specify) FOUND AT | 28b. Time of A FOUND: M 10:15 ne, farm, street, fa RESIDENC | 28c. Inju | her: 4 Nursing If at No No No No No No No No No N | Homa 5XMes 28d. Describe UNKNO 281. Location City or 7c | idence 6 Oth how injury occur WN (Street and Numb iwn, State) 150 RG, MD cause(s) and ma , dele and place, | per of Bural Boute Number. S W. LIBERTY RD. |
| | 1503 LIBERTY RO 5. Social Security Number 212-76-4057 Usual Residence of Decedent 10a. Stata 10b. County MD. CARROL 10e. Street and Number 141 WESTMINSTE 11. Marital Status 1 Never Merried 2 Married 3 Widowed 4 Divorced 15. Decedent's Ed (Specify only highest grave) Elementary/Secondary (0-12) 11 17. Fathar's Name (First, Middle, Last) CHARLES 19a. Informant's Neme/Relationship (7) CHARLES J. HARR 20a. Method of Disposition 1 Burlal 2 Cremation 3 Method of Disposition 1 Burlal 2 Cremation 3 Method of Disposition 1 Signatura of Funeral Service Licen 1 Signatura of Funeral Service Licen 1 Sequentially list conditions, if any, leading to immediate cause (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or Injury that Initiated evants rasulting in death) Last | Usual Residence of Decedent 10a. Stata 10b. County 10c. City MD. CARROLL W MD. CARROLL W 10e. Street and Number 1 4 1 WESTMINSTER AVE. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Merried 2 Married 3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grada completed) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) CHARLES JOSEPH HARR 19a. Informant's Neme/Relationship (Type, Print) FATHER CHARLES J. HARRIS, SR. 20a. Method of Disposition 1 Burlal 2 Cremation 3 Removal from Stata Celebrate A Donation 5 Other (Specify) 21. Signature of Funeral Seffice Licensee 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, Give Year or Dates: 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, Give Year or Dates: 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, Give Year or Dates: 1 | 1503 LIBERTY ROAD 5. Social Security Number 212-76-4057 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location MD . CARROLL WESTMINSTER AVE. 11. Maritel Status 1 Never Merried 2 Married 3 Widowed 4 Divorced 11. Specify only highest grada completed) Elementary/Secondary (0-12) 11. Father's Name (First, Middle, Last) CHARLES JOSEPH HARRIS, SR. 19a. Informant's Neme/Relationship (Type, Print) FATHER 19b. Meiling Ad CHARLES J. HARRIS, SR. 20a. Method of Disposition 1 Description 2 Description 3 Description 3 Description 3 Description 3 Description 3 Description 3 Descr | 1503 LIBERTY ROAD 5. Social Security Number 212-76-4057 MM 2 F | 1503 LIBERTY ROAD 5. Social Security Number 212-76-4057 Usual Residence of Decedent 10a. State 10b. County MD. CARROLL 10c. City, Town or Location WESTMINSTER 10d. Zip Code 141 WESTMINSTER AVE. 11. Marital Status 11. Marital Status 11. Marital Status 12. Was Decedent Ever in U.S. 11. Marital Status 12. Was Decedent Ever in U.S. 11. Mary Security Mymbers grade completed) 11. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11. Father's Name (First, Middle, Last) CHARLES JOSEPH HARRIS, SR. 12. Was Decedent's Usual Occupation (Ghe find of work done entired) 13. Was Decedent's Usual Occupation (Ghe find of work done entired) 14. MASON 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) CHARLES JOSEPH HARRIS, SR. 18. Mother's Name (First, Middle, Last) CHARLES JOSEPH HARRIS, SR. 19a. Informant's Neme/Relationship (Type, Print) FATHER 19b. Melling Address (Street and Number or Father) 15a. Mason 15b. Melling Address (Street and Number or Father) 15c. Decedent's Education (Name of cemetery, crematory or other place) MEADOW BRANCH CEM. 15b. Decedent's List only one of use on each line. 15c. Decedent's List only one of use on each line. 15c. Due to (or as a consequence of): 15c. Due to (or as a consequence of): 15d. Due to (or as a consequence of): 15d. Due to (or as a consequence of): | S. Social Security Number 6. Sex 212 - 76 - 4057 12 M 2 F 7. Age (In yrs. lest birthday) H Under 1 Year H Under 24 Hs. 8. Date of B (Anoth) 8 / 20 / 20 / 20 / 20 / 20 / 20 / 20 / | 46. City, Town, or Location of Death 46. City, Town, or Location of Death 46. County 1503 LIBERTY ROAD 5. Social Security Number 6. Sax 212-76-4057 1 M 20 F 7. Age (in yrs. lest birmday) 42 Yrs. 10sual Residence of Deadednt 10a. State 10b. County MD. CARROLL WESTMINSTER 11. Merital Status 12. Merital Status 13. Was Decedent of Hispanic Origin? (Specify Yes on No. Plant Record of No. P |

DHMH 16 Rev 6/95

State Registrar

B. Sparks



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Deta of Deeth **Physician** Month HEALEY MURIEL 15 /Medicai Jan 2000 7:48 PM 4e. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Genesis ElderCare -Easton The Pines Talbot If Under 1 Yaar If Under 24 Hrs. 8. Data of Birth (Month, Dey, Year) 5. Sociei Security Number 7. Age (In yrs. last birthday) 9. Birthplace (Stete or Foreign **Funerai** 1□M 2XF Months 34-03-3496 Yrs. Director CT. 28 1911 Usual Residence of Decedent the Marylend 10a. State 10h County 10c. City. Town or Location ?7 is marked other than "natural", or itema 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10d. inside City Limits 1⊋Yas 2□No Director PA. CUMBERLAND MECHANICSBURG 10e, Street and Number 10g. Citizen of What Country? 1100 Grandon WAY 17055 USA Funeral 12. Wes Decedant Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Datas: Race - American Indian, Biack, White, etc. 11 Marital Status Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 1 ☐ Nevar Marriad 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: þ Specify: WHITE 3 Widowed 4 □ Divorced permit. Peges 1 and 2 should be filed within 72 hours Department of Heelth and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic avent Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usuel Occupation (Give kind of work dona during most of working life, DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) Coilege (1-4or 5+) HOUSEWIFE HOUSEWIFE 17. Father's Name (First, Middla, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be BRITT HLFRED CLARA TRAUB 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 25702 GAIL E. BULLER - DAUGHTER LANK DENTON MD 31639 1/21/2cc 20b. Place of Disposition (Nema of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Buriel 2 Cremation 3 Removal from State Ersuille Mennonite MILLEYSUILLE, PA 4 □ Donetion 5 □ Other (Specify) 22. Name and Addrass of Facility
WILLIAMSEN FURY A 21. Signature of Funaral Servica Licensee Home 23a. Part1. Enter the diseasa, or complications that caused the death. Do not enter the mode of dying, such as carefactor respiratory errest, shock, or haert failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in death) Examiner burial-transit certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Lest end P.O. Box 68760. physician Physician/Medical Due to (or es e consequenca of) the guipo etten for signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributa to the cause of death? 1 Yes 2 No 3 Probably 4 ☐ Unknown Division of Vital Records, þ 24b. Wera autopsy findings evallable prior to complation of cause of deeth? Completed 24a. Was an autopsy performed? рееп 212 No After this certificate 1 Yes 2 No To the Hospital or Attending Physician: director. 25. Wes casa referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No 1 Inpatient 2 ER/Outpetlent 3 DOA within 24 hours after deeth.

To the Funeral Director: After this completely filled in by the funeral 28e. Dete of Injury (Month, Day Year) 27. Manner of Deeth 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 5 Pending invastigation Naturel 1 Yes 2 Accident 6 Could not be determined 3 Suicide 28e. Pleca of Injury - At home, farm, street, fectory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Steta) 4 Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at tha tima, data and place, and due to the ceuse(s) end mennar es stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end manner stated. (Check only one) 29b. Signature and title of o 29c. Licansa number 29d. Data signed (Month, Day, Year) MD 00 30 Neme and eddress of person who completed cause of death (Item 23e) (Type, Print)

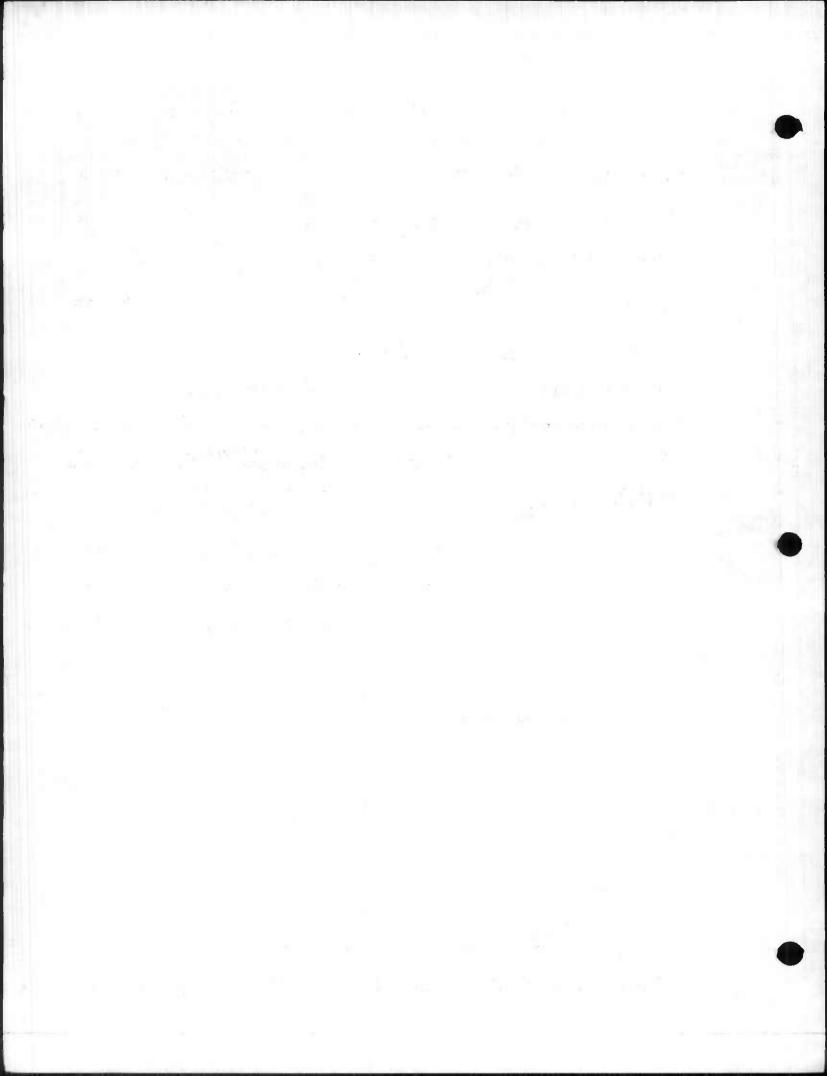
MD

32. Registrar's Signature

508

State Registrar 31. Date filed (Month, Day, Year)

JAN 1 9 2000



Plea

Audre Danielle Harris

Director

Funeral

à

Be Completed

| lle Harris | | se Type or State o | | land / D | epar | tmer | it of | Health | and N | II Coples Jental Hy | | egibi | | 1228 | n |
|--|-------------------|-----------------------|-------------------------|----------------------|---------|---------------------|----------|--------------|-----------------|--|-------------|---------------------------------|----------------|----------------------------------|--------------|
| | | | | (| Serti | iticat | e of | Death | | | Reg. No. | 00 | - 1 | | |
| 1. Decedent's Name | e (First, Middl | | | | | | | | | 2. Date of De Month | eath Day | Y | /ear | 3. Tima of I | Death |
| AUDRE | | DANIELLE | | HAR | RIS | | | | | Januar | | 200 | 00 | 10:04 | A.M. |
| 4a Facility Name (/ | f not institution | n, give street and nu | ımber) | | | | | 4b. City, To | own, or L | ocation of Deat | h 4c. 0 | County of | Death | | |
| Universit | y of M | Maryland M | 1edica | 1 Cent | er | | | Balti | more | | | N | N/A | | |
| 5. Social Security N 219-98-6 | | 6. Sex 1 ☐ M 20(F | 7. Age (In 31 | yrs. last birth Y | | If Unde Months | Days | | 24 Hrs. Min. | 8. Date of Bill (Month, D) March | 70 Year) | 58 Wa | Birthi Coun | place (State or otry) ington, | Foreign D.C. |
| Usuat Residence of | Decedent | | | | | | | | | | | | | | |
| 10a. State | 10b. County | | 100 | . City, Town | or Loca | ition | | | | | | | | 10d. Inside City | Limits |
| Maryland | Calv | ert | | Nor | th | Bead | ch | | | | | | | 1X Yes | 2 🗆 No |
| 10e. Street and Nur 9308 S | | Court | | | | 10f. Zip | Code | 20714 | | | 10g. Citiz | on of Wh | | ntry? | |
| 11. Marital Status 1 Never Marri 3 Widowed | ed 2 X Man | H Yas G | orces? 2 🐧 No ive | in U,S. | If Y | as Dece res, spe | cify Cul | ban, Mexica | n, Puerto | pecify Yes or No Rican, etc.) | | I. Race - Bleck, Specify: | White, | can Indian, etc. ite | |
| | 15 Deceden | t's Education | | 168. |)eceder | nt's Usu | al Occu | pation | | | 16b. Kin | d of Busin | ness/In | dustry | |

3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 File Maintenance Clerk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname)

William E. C. Flammer

4 ☐ Donation 5 ☐ Other (Specify)

Willie Mae Burrass

Safeway

19a. Informant's Name/Reletionship (Type, Print)

19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 9308 Sea Oat Court, North Beach, Maryland

Robert S. Harris, Jr., Husband 20e Method of Disposition 1 X Buriat 2 ☐ Cremation 3 ☐ Removal from State

20b. Place of Disposition (Name of cemetery, cremetory or other place) Date 20c. Location - City or Town, State Trinity Memorial Gardens 01-17-2000 Waldorf, Maryland

21. Signature of Fungral Service Library MARK G. **BROHAWN** M00053

22 Name and Address of Facility
The Huntt Funeral Home, Inc. P.O. Box 156, Waldorf, Maryland 20604

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)

Due to (or as e consequenca of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of)

Due to (or as a consequence of):

Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1 Yas 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

24b. Were autopsy tindings available prior to completion of cause of death?

Approximate Interval Between Onset and Death

2□ No

1 Yes 2 No

26. Place of Death (Check only one)

Hospital: 1 Xinpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28c. tnjury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of Injury

28d. Describe how injury occurred A LOTHOR CAR Deiven of use in coursion wins

28f. Location (Street and Number or Rural Route Number, City or Town, State)

RODOWNY

BRYFYS PO CHARLES CO YW

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Sighature and title of certified

8

O.C.M.E.

29d. Date signed (Month, Day, Year) January 13, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201 LOREN MITIS (W)

State Registrar

filled in by

within 24 hours a To the Funeral D

To the

DHMH 16 Ray 6/95

Physician /Medical Examiner **Funeral** Director

is 23s or 25s-f show must be notified at ò

filed within 72 hours after Pages 1 and 2 should be nent of Health and Mental . of of Health is if Item 27 is permit. Page Department of Important: If any injury or other.

Physician

/Medical **Examiner**

943

980 ò

Baltimore, Maryland 21215-0020

The lew requires that the death certificate be executed Division of Vital Records, P.O. Box 68760. attending physician signed by Hospital or Attending Physician: After after death.

Be Completed by this certificate has pege . 25. Was case referred to medical 1 Yes 2 No Medical Certification: To

Physician/Medical Examiner

27. Manner of Death 1 Natural
2 Accident

29a. Certifier

3 Suicide 4 Homicide

5 Pending investigation

6 Could not be determined

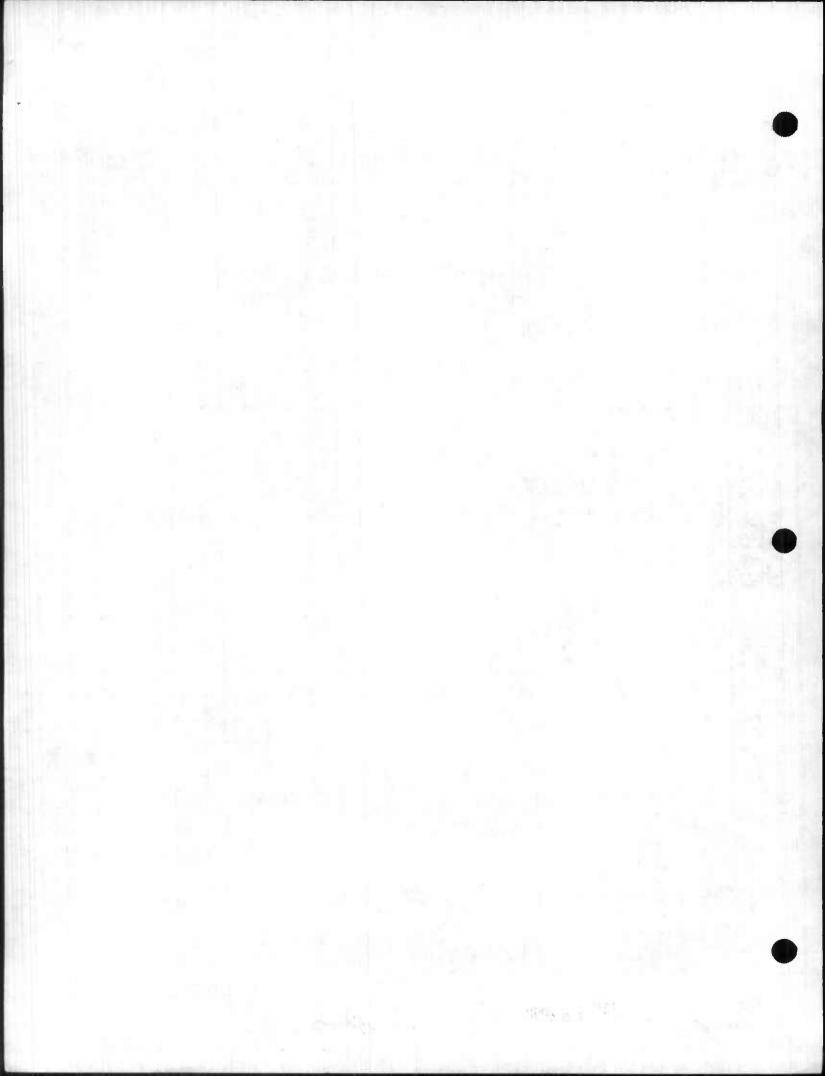
1-11-00

04568

28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

29c. License number

32. Registrar's Signature 2000



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** ERNEST ITHEN HOUSE JANUARY 15 2000 6:33am /Medical 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE TOWSON GREATER BALTIMORE MEDICAL CENTER If Under 24 Hrs. 8. Date of Birth Month, Day, Year) MARCH 26 1902 5. Social Security Number 6. Sex. 1 AM 2 F 7. Age (In yrs. last birthday) If Under 1 Year 9. Birthplaca (State or Foreign **Funeral** Months Hours MARYLAND 217-10-4916 Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director 28a-f MARYLAND ALLEGANY CUMBERLAND 10a Street and Number 10f. Zio Code 10g. Citizen of What Country? 8 21502 U.S.A. 510 SCHLUND AVENUE Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 24 DNo If Yes, Give Yeer or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Merried 8 1 ☐ Yes 2 No Specify: Specify: WHITE å 3 □ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) CELANESE CORP OF AMERICA SILK MANUF. Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 and Mental ROSE PROUTT JOSEPH MARTIN HOUSE 2 1 and 2 should 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informant's Name/Relationship (Type Print) Item 27 is DAUGHTER 3313 NORTHWIND ROAD BALTIMORE MARYLAND 21234 VIRGINIA GLOTFELTY 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other place) Date 20c. Location - City or Town, Stata Pages 1 XBurial 2 Cremetion 3 Removel from Stete ZION CEMETERY JANUARY 18 2000 CUMBERLAND MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funerel Service Licensee 22. Name and Address of Facility MERRITT-ADAMS FUNERAL HOME P.A. 23a. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one cause on each line. Approximate Intervel Between Onset end Death **Physician** /Medical Immediate Cause (Finel neumonra 2 Weeks diseese or condition resulting in death) Examiner Examiner UNK Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last The law requires that the death certificate be axecu Box 68760. Physician/Medical the the Due to (or es a consequence of) signed by the a 23b. Did tobacco use contribute to the cause of death? P.O. Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Division of Vitai Records. þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an eutopsy performed? Completed page 2 1 Yes 2 No 1 ☐ Yes 2 ☑ No certificate Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 In Impatient 2 □ ER/Outpatient 3 □ DOA this 27. Manger of Death 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? After 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after deat Funeral Director: 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. To the Fune completely f (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and menner steted. To the To the To the 29b. Signature and title of certifie 29c. License number 29d. Dete signed (Month, Day, Year) telurence mo 00 ess of parson who completed cause of death (Item 23a) (Type, Print) Baltimore Medical Conter 6701 N. Charles St nes

DHMH 16 Ray 6/95

Registrar

Beltomore, mo 21204

32 Registrer's Signature

mension of the MA

| # 8. | Per Fam. PGC 1-19-2000 cr C6 1. Decedent's Neme (First, Middle, Last) | ertificate of | Death | 2. Date of Dea | | 3. Time of Death |
|----------------|---|--|--|---|--------------------------------------|--|
| ician dical | Norah Hassler | | | Month January | Dey 12 2 | Yeer 2000 5:08 a.m |
| iner | 4a Facility Name (If not institution, give street and number) | | 4b. City, Town, or L | ocation of Death | 4c. County of | of Death |
| al | 8809 Patricia Court, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) | | College P | | Prince | George's |
| | 579-44-8730 1 M 2 F 91 Yrs. | Months Days | | 8. Dete of Birth (Month, Dey | | 9. Birthplece (State or Foreign Country) [reland |
| | Usual Residence of Decedent 10e. State 10b. County 10c. City, Town or L | ocation | | April 14 | | 10d. Inside City Limits |
| 0 | Maryland Prince George's College I | | | | | 1 Yes 2 No |
| Director | 10e. Street and Number | 10f. Zip Code | | 1 | log. Citizen of W | hat Country? |
| a D | 8809 Patricia Court | 20740 | | 1 | U.S.A | |
| by Funeral | 11. Merital Status 1 Never Merried 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yes, Give Yeer or Detea: | Wes Decedent of If Yes, specify Cub 1 ☐ Yes 2 ☐ No | Hispanic Origin? (Spoan, Mexican, Puerto Specify: | pecify Yes or No- Pican, etc.) | Black | - American Indien, k, Whita, etc. White |
| pa combiated | (Specify only highest grade completed) (Give Elementary/Secondary (0-12) College (1-4or 5+) | edent's Usuel Occu e kind of work done DO NOT use retire retary | pation during most of work ad) | king | 16b. Kind of Bus | siness/Industry Government |
| o Be Co | 17. Father'a Name (First, Middle, Last) William Hurley | | 18. Mother's Nem Unavail | | Maiden Sumeme | 9) |
| - | 19a. tnformant's Neme/Reletionship (Type, Print) 19b. Meil | ing Address (Stree | t end Number or Ru | ral Route Numbe | r, City or Town, | State, Zip Code) |
| | T | | Court, (| | | |
| | 1 ☐ Burial 2 M Cremetion 3 ☐ Removel from Stete | emetory or other ple | | | | City or Town, Slete |
| | 4 Donation 5 Other (Specify) Metropolis 21. Signature of Funeral Service Libensee | | | | | ome, P.A., |
| | | | | | | ome, P.A., e, Maryland |
| | 23a. Part1. Enter the disease, or complications that caused the deeth. Do not en shock, or heart failure. List only one cause on each line. | | | - | | Approximate Interval Between |
| | | | | | | Onsel and Deeth |
| | Immediate Cause (Finel disease or condition resulting in death) Due to (or as a conse | | | | | 48 km |
| Jer | Dué to (or as a conse | equence of): | Th. 10 | anni. | , | 5 days 5 days |
| Examiner | Sequentially list conditions, Due to (or es e conse | equence of): | cing in | Cicoco | | 30095 |
| cal E | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Due to (or es a conse | ion / 1- | ecal ? | Lmpac | Tion | 5 days |
| 8 | resulting in death) Last | quence of): | | | | |
| an/M | d | | | | | |
| Physician/M | Pert II. Other significant conditions contributing to death but not resulting in the | underlying cause gi | iven in Pert I. | 23b. Dfd to | obacco use con | tribute to the cause of death? |
| | ALZheimer's D. | sease | _ | 101 | 188 30 No | 3 Probably 4 Unknown |
| Completed by | | | | 24a. Wes a perfor | | 24b. Were autopsy findings available prior to completion of cause of death? |
| E O | | | | 10Y | ea 2 No | 1 Yes 2 No |
| Be C | 25. Was case referred to medicat examiner? | | 26. Place of Dea | th (Check only or | ne) | |
| 10 | 1 Hospitel: 1 Inpalient 2 ER/Outpatie | SHE SLIDON | | oma 5X Resid | | |
| Certification: | 27. Manner of Death 1. Watural 5 Pending investigation investigation | Wo | ork? ∃Yes 2∐No | 28d. Describe h | ow injury occurre | ed |
| TICA | 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, ferm, si | | | | | er or Rural Route Number, |
| Cert | 4 ☐ Homicide building, efc. (Specify) | | | City or Tow | n, Stete) | |
| edical | 29e. Certifier (Check only one) 2 Medicat Examiner: On the basis of examinetion and/or in and menner steted | th occurred at the ti nvestigation, in my | ime, dete and place, opinion, deeth occur | , and due to the c rred at the time, o | ause(s) and mai late end place, a | nner as stated. and due to the cause(s) |
| Med | 29b. Signeture and little of certifier | 29c. Licen | se number | 2 | 29d. Date signed | (Month, Day, Year) |
| | . 0) | 72 | 0111 | | | |
| | 30. Name and address of person who completed cause of deeth (Item 23a) (Type | Print) | - , , (| | | J 12 2000 |
| | Gary w Jones MD P. | 0 Box 31 | 85 Laur | es me | 1 207. | 25-0385 |
| tate | 30. Name and address of person who completed cause of deeth (Item 23a) (Type Gary W Jones M) 31. Date filled (Month/Day, Year) 32. Registrar's Signeture | Print) Box 31 | 0 111 85 Laur | res Me | 1 207. | 25-038 |

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State of Maryland / Department of Health and Mental Hygiene

| Date of Freedry Name (if red carefolium) survey arrivated uniformity Martiner Circle Manor Nursing Home Kensington, Mp. Social Security Number 114-26-7621 115-26-26-26-26-26-26-26-26-26-26-26-26-26- | | 1. Decedent's Name (First, Middle, Las | st) | | | | 2. Date of De Month | ath Day | Year 3 | . Tima of Death | |
|--|-----|--|--|---------------------|-----------------------|----------------------------------|------------------------|----------------------|----------------|---------------------------------|----|
| April Circle Manor Nursing Home Mariner Circle Manor Nursing Home Mariner Circle Manor Nursing Home Mariner Circle Manor Nursing Home Mariner Circle Manor Nursing Light Mariner Light Mariner Light L | | Daisy B. | Hunter | | | | | | | 11:40pm | |
| S. Social Socially Number 114 - 26 - 76 - 21 11 | - | 4a Facility Name (If not institution, give | a street and number) | | | 4b. City, Town, or L | ocation of Deat | 4c. County | of Death | | |
| 114-26-7621 Tubus Residence of Decoders Tubus Residence of Decoders of Residence of Reside | | | | | | | | | , , | | |
| 100. Street and Number 100. Cay, Town of Location Washington, D.C. 100. Street and Number 230.0 Good Hope Rd., SE. Apt. 813 107. Zp Code 109. Citizen of What Country? United States 11. March Brade 2 Married States 12. Was Depoting to Price in U.S. 13. Was Depoting to Hispatic Country (Specify City) 14. Flazar A marrian holds. | | 114-26-7621 | TH ME | | | | | | | | [_ |
| Was Singston, J. C. | | | 10 | c. City, Town or L | ocation | | | | 10d. | Inside City Limits | |
| Specify | | | | Washing | | | | | 100 | *** | _ |
| Specify Spec | | | I. SE. Ant. | 813 | 10f. Zip Code | | | | | | |
| Specify: | 3 | | | | Was Decedent of | | pacify Vas or No | | | | _ |
| Sanford Augustus Brookins Leola Calloway 19th Internate's Name (Prist, Modes, Mastern stress) 19th Internate's Name (Prist, Modes, Mastern stress) 19th Mailing Address (Street and Number or Pairal Route Number. City or Town. State, Zp Code) 200 | | 1 Never Married 2 Married | Armed Forces? 1 Yes 2 No If Yes, Give | | | | Rican, etc.) | Btac | k, White, etc. | | |
| 19. Informar's Name (Parts, Actor), Mactors, Last) | | | | 16a. Deci | edent's Usual Occ | upation e during most of work | kina | 16b. Kind of Bu | usiness/Indust | iry | |
| Sanford Augustus Brookins Leola Calloway 19th Internate's Name (Prist, Modes, Mastern stress) 19th Internate's Name (Prist, Modes, Mastern stress) 19th Mailing Address (Street and Number or Pairal Route Number. City or Town. State, Zp Code) 200 | | | | | | | | U.S. Po | stal S | ervice/ | |
| Sanford Augustus Brookins Leola Calloway 19st Informart's NamoPalealistoraphy (Type, Print) Barry R. Burns (Son) 300. Mailting Address (Street and Number or Pausi Route Number. City or Town. State, Zip Code) 2300 Good Hope Rd. SE., Apt. 813 Wash, Dc. 200 200. Method of Disposition Signature of Completion of Signature of Designation of Signature of Comments of Signature Of Signature Of Signature of Comments of Signature Of Signature of Comments of Signature Of Signatur | - | | 4 | Pos | car Ciei | | o /First Middle | | | пшепс | |
| 196. Making Address (Streat and Number or Rural Route Number, City or Town, State, Zip Code) Barry R. Burns (Son) 200. Method of Disposition 1 | 3 | | | | | | | | 10) | | |
| Barry R. Burns (Son) 2300 Good Hope Rd. SE., Apt. 813 Wash, DC. 200 | : | | | 405 14-9 | ing Address (Ct | | | | State 7in C- | del | |
| 20a. Method of Disposition 1 Maurial 2 (Ceramation 3 Removal from State 4 Donation 5 Coherander (Specify) 21. Signature of Lineral Service Licensee 4 Donation 5 Coherander (Specify) 21. Signature of Lineral Service Licensee 4 Donation 5 Coherander (Specify) 22. Name and Address of Facility Pope Funeral Homes, 5538 Mar1boro Pike Forestville, Marvland 20747 23a. Part Enter the disease of Conditions that susued the death Donate of the rise and specific properties and s | | A STATE OF THE PARTY OF THE PAR | | | | | | | | | |
| 1 | ŀ | | | 20b. Place of Disp | osition (Name of | | - | | | | |
| 23a. Part. Enter the disease of complications that faunched the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart feiture. Use only one cause or medical the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, Immediate Cause (Final disease of conditions) a. CARDIOMYOPATHY Due to (or as a consequence of): a. CARDIOMYOPATHY Due to (or as a consequence of): d. Due to (or as a consequence of): d. Due to (or as a consequence of): 4. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HYPERTENSION, SEPSIS Due to (or as a consequence of): 25. Wes case referred to medicat saleminer. 25. Wes case referred to medicat saleminer. 26. Place of Death (Check only one) 27. Manner of Death (Check only one) 28. Death (Check onl | 1 | 1 Burial 2 ☐ Cremation 3 ☐ | | | | 1 | /15/00 | D a to- | d N | (a.m. 1 a.m.) | |
| Pope Funeral Homes, 5538 Marlboro Pike Forestville, Maryland 20747 23a. Part. Enter the disease or complications that guided the death. Due not enter the mode of dying, such as cardiec or respiratory arreal. Immediate Cause (Final diseases or coordillon) resulting in death) Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): The indised events are the disease or conditions, and the death but not resulting in the underlying cause given in Part I. HYPERTENSION, SEPSIS Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HYPERTENSION, SEPSIS 24a. Was an autopsy performed? 25b. Was case referred to medicat are strained? 1 Yes 2 No | - | | <u> </u> | | | | /13/00 | Brentw | 700a, M | laryland | _ |
| 28. Part I. Enter the disease, or completations than fauntied the death. Do not enter the mode of dying, such as cardisc or respiratory arrest, Approximatificational before and interval the content of the mode of dying, such as cardisc or respiratory arrest, Approximatificational before and interval the content of the cause of the cause of the content of the cause of th | | · Cara | 200 | 6. OH E | ope Fune | eral Homes | | Marlbord | Pike | | |
| Immediate Cause (Final death of conditions of conditions as a consequence of): | | 23a Part 1 Enter the disease of domi | olications that have let the | death Do not ex | orestvil | le, Maryl | and 20 | 747 | Ar | occavimate | - |
| Sequentially list conditions Sequentially list list list list list list list list | | shock, or heart feilure. List only | one cause or each line. | | | , , | | | Int | erval Between nset and Death | |
| Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury resulting in death) Last Due to (or as a consequence of): | | Immediate Cause (Final | CARRIONS | OD A DIXX | | | | | | MONTHIO | |
| Sequentially list conditions, it any, leading to simmedate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or | | resulting in death) | a | | Augusta off: | | 1.1 | | 1 2 | MONTHS | - |
| Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a | 90 | | | 10 (01 93 9 60136 | quence or. | | | | | | |
| Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a | E | Sequentially list conditions | b | to (or as a conse | quence of): | | | | 1 | | - |
| Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of the probability of the probability of the probability of the probability of death of the cause of the probability of the probability of death of the probability of the probability of death of the probability | | if eny, leading to immediate cause. Enter Underlying | | | | | | | | | |
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| 25. Wes case referred to medicat examiner? 25. Wes case referred to medicat examiner? 1 | | | 4 | | | | | | t | | |
| 24a. Was an autopsy performed? 24b. Were autopsy performed? 25c. Wes case referred to medicat examiner? 1 | | | 0. | | | | | A south | 1 | | |
| 24a. Was an autopsy performed? 24b. Were cause referred to medical aveilable prior to completion of confeath? 1 | 316 | Part II. Other significant conditions or | ontributing to death but n | ot resulting in the | underlying cause | given in Part I. | 23b. Did | tobacco use co | ntribute to th | e cause of death? | |
| 25. Wes case referred to medicat examiner? 25. Wes case referred to medicat examiner? | | HYPERTENSION. SEI | PSIS | | | | 10 | Yea 2□ No | 3 Probeb | ly 4 Unknown | j |
| 25. Wes case referred to medicat examiner? 1 | 107 | | | 7 | 17 | | 04-111 | | 24h Mar- | Butanes findings | |
| 25. Wes case referred to medicat examiner? Second Se | 200 | | | | | | 24a. Was | an autopsy ormed? | aveila | ble prior to letion of cause | |
| 25. Wes case referred to medical examiner? 1 | Ē | | | | | | | ** | of dea | ith? | |
| 1 Yes 2 Number of Death 1 Inpatient 2 ER/Outpatient 3 DOA Other: 42 Nursing Home 5 Residence 6 Other (Specify) | | | | | | | 10 | Yes 2 No | 1 D Y | es 2 No | |
| 27. Manner of Death 1 | 1 | examiner? | Hospital: | | 10 | | | | | | |
| 2 Accident 3 Suicide 4 Homicide Suicide 4 Homicide Suicide 5 Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Num City or Town, State) 29e. Certifier (Check only one) Check only one) Che | 1 | 1 192 57740 | 1 LI Inpatient | | INT 3LI DOA | 4th Nursing H | | | | | |
| 29e. Certifier (Check only one) 29e. License number 29e. License number 29e. License number 29e. License number 29e. Date signed (Month, Day, Year) 29e. Tanuaky, 11, 20e. | 5 | 1XXXIII 5 Pending | (Month, Day Ye | | | | 200. Describe | now injury occur | | | |
| 29e. Certifier (Check only one) 29e. License number 29e. License number 29e. License number 29e. Date signed (Month, Day, Year) 28656 28656 29e. License number 29e. Date signed (Month, Day, Year) | 3 | 3 Suicide 6 Could not be | | At home farm e | | | 281. Location / | Street and Numb | ber or Rural R | oute Number | |
| 29e. Certifier (Check only one) 29e. Certifier (Check one) 29e. Certifi | | data-minad | 289. Place of injury | pecify) | ireet, ractory, offic | | City or To | wn, State) | w nuisi n | sate Harrisol, | |
| 29c. License number D 28656 DANUARY, 11, 200 | 1 | 29e Certifier | veiclen: To the best of | u knowladza d | th non-mad at the | time data and slave | and due to the | enuco(e) and m | anner en elet | wd. | |
| 29c. License number 29d. Date signed (Month, Day, Year) D 28656 JANUARY, 11, 200 | 200 | (Check only / 2 Hedical Exam | niner: On the basis of exa | mination and/or is | nvestigation, in my | opinion, death occur | rred at the time, | date and place, | and due to the | e cause(s) | |
| D 28656 JANUARY, 11, 200 | ž | 1 / | and market stelled | | 29c. Lice | nse number | | 29d. Date signe | d (Month, Da | y, Year) | |
| 7,1,200 | | | | | 7 | 28656 | | | | 7000 | |
| The street and address the street of the str | 1 | JAK JAK | | | 12 | | | THE TOTAL | 1)1 | 2000 | |
| RAVI PASSI M.D. 8609 2nd Avenue, Suite 404-B, Silver Spring, MD. 2091 | | | | | | | 5.1.5 | 0 | 100 | 20910 | |

Please Type or Print in Black indelible ink. Assure Ali Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 3. Tima of Death 2. Data of Death Month **Physician** LUCY HALL JANUARY 5,2000 3:09 am /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner SOUTHERN MARYLAND HOSPITAL CLINTON PRINCE GEORGES Months Days Hours Min. APRIL 3, 1914 5. Social Security Number 7. Aga (In yrs. last birthday) 9. Birthplace (Stata or Foreign **Funeral** 1□M XXF 85 WASHINGTON DC Director 579-32-2811 Usual Rasidence of Decedant 3 0/3 Purify 8 10a Stata 10c. City, Town or Location 10b County 10d. Inside City Limits mant be notified at 1 ♥ Yes 2 No Director PRINCE GEORGES SUITLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2016 SPAULDING AVE 20746 UNITED STATES Funeral 12. Was Decedent Evar in U,S. Armed Forcas? 1 ☑ Yas 2 ☐ No If Yas, Giva Yaar or Datas: Nome 2 Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. 11 Marital Status "natural", or iten Pages 1 and 2 should be filed within 72 hours after of health and Mental Hygiene.
int: If Item 27 Is marked other than "natural", or itel
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ALEXANDER S. POPE FUNERAL 21. Signatura of Funaral Sarvice Licensee Summers Lapr 5538 MARLBORO PIKE, FORESTVILLE, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intarval Between Onset and Death Physician /Medical Immediata Causa (Final disaasa or condition rasulting in daath) Condine an/hure Examiner Examiner hysician and the burial-transit The law requires that the death certificate be assecuted Sequentially list conditions, if any, leading to immadiate cause. Entar Underlying Causa (Disaasa or Injury that initiated evants rasulting In death) Last Due to (or as a consequence of) Box 68760. Denetia Physician/Medical Dua to (or as a consequence of): for use as Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. P.O. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown Sacrul de cubitas Division of Vital Records. Completed by 24a. Was an autopsy performed? 24b. Ware autopsy findings available prior to SIP Tracheostenycompletion of cause of death? certificate has page 2 1 Yas 2 No 1 Yas 2 No or Attanding Physician: 25. Was casa refarred to medicat axaminar? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) 1 Yas 2 No Certification: To 1 Inpatient 2 PER/Outpatient 3 DOA After this 28a. Data of tnjury (Month, Day Year) funeral 27. Manper of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Panding invastigation after death. Director: Aft 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not be datermined 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) filled in by 4 I Homicida 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) within 2 9 29c. License number 29d. Data signed (Month, Day, Year) 0 somad 30. Nama and addrass of person who completed causa of daath (Item 23a) (Type, Print) SOUTHERN AVE, WASHING TON DC 20032 K. DAVACHI, MD 1328 31. Data filed (Month, Day, Year)

JAN 1 2 2000 32. Registrar's Signatura State Registrar

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Louise Theresa Herbert 2000 7:45 P.M. Jan 10 * /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not Institution, give street and number) 4c. County of Death **Examiner** Prince George's Larkin-Chase Nursing Home Bowie If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1 M 200 F Hours Min. Yrs. 91 Nov. 15, 1908 Washington DC Director 579 05 7866 Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City. Town or Location 10d. inside City Limits 7 is marked other than "naturel", or itema 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 1 Yes 2 No Maryland Directo Anne Arundel Davidsonville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1743 Lerch Farm Court 21035 United States Funeral 2 should be filed within 72 hours after death and Mental Hygiene.
is marked other than "naturel", or itema 23 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2₹ No If Yes, Give Yeer or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Specify: White 1 Yes 2000 Specify À 3 ☐ Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation Give kind of work done during most of working life. DO NOT use retired) Atomic Energy Elementary/Secondary (0-12) College (1-4or 5+) Commission Communication Chief 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) Fritz Ganzhorn Mary Farr permit. Pages 1 and 2 shc.
Department of Health and N.
Important: If them 27 is markany injury or other: 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Alan Herbert Son 1743 Lerch Farm Court Davidsonville Maryland 21035 20b. Place of Disposition (Name of cemetery, crematory or other place)

Jan. 13, D€€00 20c. Location - City or Town, State 20a. Method of Disposition 1 Burlel 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lakemont Memorial Gardens Davidsonville MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home, Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Appreciations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Appreciations are cardiac or respiratory arrest. Physician Atherosclerotic Heart Disean /Medical Immediete Cause (Final disease or condition resulting in death) Examiner Examiner physician and the burial-tran Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): the death certificate be exect Division of Vital Records, P.O. Box 68760, Physician/Medicai Due to (or as a consequence of) 98 Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the ceuse of death? typothyxi dism 1 Yes 2 No 3 Probably 4 Unknown signed I à 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical exeminer? 26. Place of Death (Check only one) Be Other: 4 Uursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 10 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: After ! or Attending 5 Pending 1 Matural 2 No 2 Accident 1 Yes Investigation after death Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours Hospital 1 Certifying Phyetcian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. 29a. Certifier Medical (Check only one) To the To the To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier anong MI 20100 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 14300 Gallant Fox Lane Bowle M D MP

Registra

31. Date filed (Month, Day, Year)

JAN 1 2 2000

32. Registrar's Signature

PEUS VIEWAL.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death @ Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth ALANA HICKMAN 4b. City, Town, or Location of Deeth CHEVERLY, WE 4e Fecility Neme (If not institution, give street and number, Z-Age (In yrs. last birthday) If Und SEORGES RINCE If Under 1 Year | If 8. Dete of Birth (Month, Dey, Year) January 24, 1978 Guyana, America 5. Social Security Number Months 10 M 20 Deys Hours Min. Yrs. Usual Residence of Decedent 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No BERBICE 10a Street and Number 10f. Zip Code 10g. Citizen of Whet Country? N/A 80 Princetown Corriverton Guyana 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien. Bleck, White, etc. 1 Yes 2 No If Yes, Give Yeer or Detes: 1X Never Merried 2☐ Merried 1 Ves 2K No Specify Specify: African-Guyanese 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementery/Secondary (0-12) Student Education 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Father's Neme (First, Middle, Last) Susan Williams Sidney Hickman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) South 19e. Informent's Neme/Reletionship (Type, Print) 80 Princetown Corriverton Berbice, Guyana America Truda Hickman/sister 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) Date 20c. Location - City or Town, State 20e. Method of Disposition | Donellon 5 Nother (Specify) Out of country Scott's Church Cem. 1-13-00 Corriverton, Guyana 22. Name end Address of Facility Marshall's Funeral Home of MD 21. Signeture of Funerel Service License 4308 Suitland Rd. Suitland, MD 20746 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest shock, or heart feiture. List only one cause on each line. Approximate Intervel Between Onset end Deeth Immediate Ceuse (Finel diseese or condition resulting In deeth) Due to (or es e consequence of): Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Disease or injury that initieted events resulting in deeth) Lest Due to (or es e consequence of) Due to (or es e consequence of) 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 ☐ Unknown 28 No 24b. Were eutopsy findings evaileble prior to completion of cause of deeth? 24a. Wes en eutopsy 1 Yes 1 ☐ Yes 2 ☐ No 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Physician /Medical **Examiner**

Physician

/Medical

Examiner

Director

Funeral

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Completed

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N/A

Funeral

Director

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WITH

72 hours after

permit. Pages 1 and 2 should be filed within: Department of Health and Marital Hygiene. Important: If teen 27 is marked other than 7

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Baltimore, Maryland 21215-0020

id other than "natural", or items 23a or 28a-1 show event, the Medical Examiner must be notified at

Physician/Medical Examiner ettending physicien end for use es the bunal-transit 98 the signed by to by pluods Completed peen hes page 2 certificete Be 0

After this funeral death. the To the Hospital or Attend within 24 hours efter death To the Funeral Directors. filled in by

The law requires that the death certificete be executed

P.O. Box 68760,

Division of Vital Records,

or Attending Physician:

Pert II. Other elgnificant conditions contributing to death but not resulting in the underlying cause given in Pert I.

25. Was case referred to medicel exeminer? 1 Yes 2 No 27. Mapner of Deeth

Naturel 5 Pending 2 Accident Investigation 6 Could not be determined 3 ☐ Suicide 4 Homlcide

Hospital: 2 ER/Outpetient 3 DOA Dete of Injury (Month, Dey Year)

end menner steted.

28b Time of

28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28c. Injury at Work? 1 Yes 2 No

28d. Describe how Injury occurred

28f. Location (Street end Number or Rural Route Number, City or Town, Stete) Ecritifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) and menner as stated.

(Check only one) 2 Medical Examiner: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certific

29e. Certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

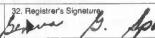
James Catavenis, M.D. 3001 Hospital Drive Cheverly, MD 20785

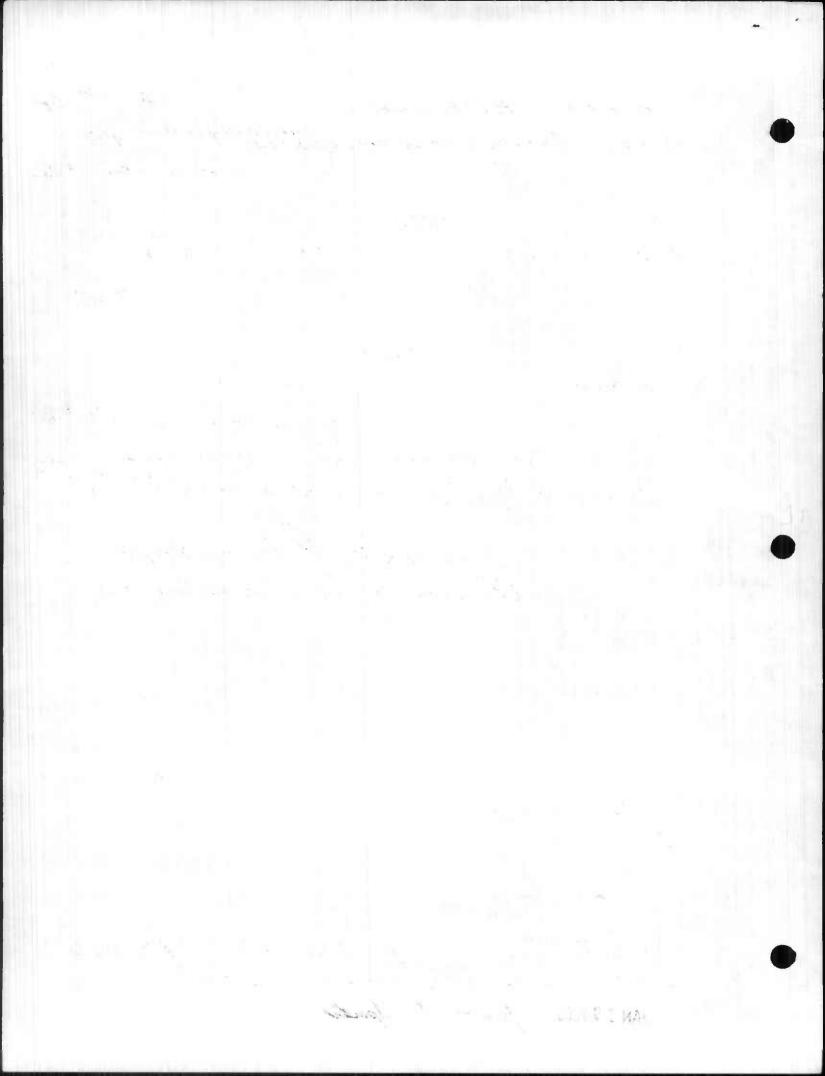
Registrar

Certification:

Medical pletely

> 31. Dete filed (Month, Day, Year) JAN 1 0 2000





Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Day Month Yeer Physician RALPH M. HACKLEY, JR. 5, 2000 5:30P.M. January /Medical 4e Facility Name (If not Institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 1005 Chillum Drive, #207 Prince George's Hyattsville If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
June 17, 1955 If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Days Months 1 □ M 2 □ F 579-76-8460 44 Yrs. Virginia Director Usual Residence of Decedent 10d. Inside City Limits 10e. Stete 10b. County 10c. City, Town or Location 1 ☐Yas 2 ☐ No Maryland Prince George's Directo Hyattsville 230-1 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 'natural', or liams 23s or 1005 Chillum Dr., #207 20782 United States Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 14. Race - American Indian, 11. Meritel Stetus Bleck, White etc. African 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: þ 3 ☐ Widowed 4 ☐ Divorced American Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) Computer Specialist Government permit. Pages 1 and 2 should be filed.
Department of Health and Mental Highlingschant. If then 27 is marked other 1 any injury or other traumatic event. It 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumame) 88 Ralph Milton Hackley, Sr. Azile R. Langhorne 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) Rhonda H. Cheatham - Sister 6121 Grenfell Loop, Bowie, MD 20720 20e. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) Date 20c. Location - City or Town, Stete 1 Buriel 2 □ Cremetion 3 □ Removel from Stete Lincoln Memorial Cem. 1/12/2000 Suitland, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Facility 21. Sign ture of Funeral Service License Stewart Funeral Home 4001 Benning Rd., N.E. Wash., D.C. 20019 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, k, or heart feilure. List only one cause on each inja. Approximete Intervel Between Onset and Death **Physician** /Medical Immediate Causa (Final diseese or condition resulting in deeth) Examiner Examine that the death certificate be executed physician and s the burial-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Box 68760 Physician/Medical Due to (or as a consequence of) 8 USB 23b. Did tobacco use contribute to the cause of death? Pert It. Other algoriticant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. 1 Yea 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings aveitable prior to completion of cause of death? 24a. Was an autopsy performed? Completed peed has 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital Be 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 X Y96 2 No 1 Inpatient 2 ER/Outpalient 3 DOA Certification: To After this 28a. Dete of Injury (Month, Day Year) 28d. Describe how Injury occurred 27. Menner of Death 28b. Time of 28c. Injury et Work? Hospital or Attending 1' Netural 5 Pending Investigation after death.

Director: Aft
d in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital
within 24 hours a
To the Funeral C 1 Cortifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29s. Certifie 29d. Dete signed (Month, Dey, Year) 295. Signature 8 00032161 1.6.00 NASIM ASHKAF 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7610 CARROLL AVE, #320, TAK TAKOMA VARK

Registrar

State

32. Registrer's Signeture

3698 F I NA

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended Item 29c, per Phy. 1/10/2000, Carroll County, wil Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death **Physician** George William Hubbard Jan 2000 6, 2:10 am /Medical 4e Facility Neme (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 4937 Pleasant Grove Road Reisterstown Baltimore If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) 9. Birthplaca (Stete or Foreign **Funeral** Months Days 1⊠M 2□F Yrs. 219-32-8661 63 Director May 7,1936 Maryland Usual Residence of Decedent the Maryland 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examiner main be notified at Reisterstown 1 Yes & No Maryland Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 21136 4937 Pleasant Grove Road USA Funeral death permit. Pages 1 and 2 should be lited within 72 hours after dea Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural". or large into into or other traumante evens. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 11 Merital Status 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: 1 Never Married 20 Married 1 ☐ Yes 2 ☒ No Specify: White by 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Black & Decker Spray Painter 18. Mother'a Neme (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) George William Hubbard Agnes Grimes 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) Claudia Hubbard, wife 4937 Pleasant Grove Rd, Reisterstown, MD 21136 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 1X Burial 2 Cremation 3 Removal from State Pleasant Grove Cemetery 1/8 Reisterstown, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatura of Funeral Servica Licenses 22. Neme end Address of Facility M00723 Eline Funeral Home 934 South Main St, Hampstead, MD 21074 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Intervat Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical Examiner Examiner certificate be executed physician end the burial-trans Sequentially tist conditions, if any, leading to immediate causa. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting in death) Lest Due to (or as a consequenca of) physician Physician/Medical Due to (or as a consequenca of) Se use 23h. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. the 1 Yss 2 No 3 Probably 4 Unknown signed by Division of Vital Records, by 8 24b. Ware autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed certificate has 1 Yes 20 No 25. Wes case referred to medical examiner? director, Be 26. Plece of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2/1 No 20 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of tnjury (Month, Day Year) funeral 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: or Attending Patter death. After 5 ☐ Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 4 Homicide To the Hospital within 24 hours a To the Funeral E Hospital edicai 29a. Certifier 🔁 Cartifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the ceuse(s) and manner as stated. 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. (Check only one) 29c. License number D26290 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (ttem 23e) (Type, Print) 29550

State Registrar 31. Date filed (Month, Day, Year)

JAN 1 0 2000

32. Registrar's Signature

5. Sparks

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Deeth 3. Time of Death 1. Decedent's Neme (First, Middle, Last) **Physician** Charles Godwin Irish , Jr. January 17,2000 11:40AM /Medical 4a Facility Name (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 7698 Ann Harbor Drive Port Tobacco If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) Charles 5. Social Security Number Birthplace (Steta or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** XXM 2 F Months Yrs. March 16, 1925 New York 74 213-20-7912 Director Usuel Residence of Decedent with the Marylend 10a Steta 10b. County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f shot traumatic event, the Modical Examiner must be notified as 1 Yes 2 No Directo Charles MD Port Tobacco 10e. Street and Number Of. Zip Code 10g. Citizen of What Country? 7698 Ann Harbor Drive 20677 U.S.A. Funeral death 12. Wes Decedant Ever in U.S. Armed Forces? 1 M Yes. 2 □ No If Yes, Give Yaar or Detes: 14. Rece - American Indien, Bleck, White, etc. 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) should be filed within 72 hours efter 1 Nevar Marriad 2 Merried Maryland 21215-0020 1 Yes 2 No Specify: Specify: White p 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decadent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade complated) Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) U.S. Government Physicist 18. Mother's Neme (First, Middle, Meiden Sumema) 17, Fether's Neme (First, Middle, Last) h and Mentel I Charles Godwin Irish Thursia Woodcock Irish 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 Is m any Injury or other traum page. 7698 Ann Harbor Dr. Port Tobacco, MD 20677 Fannie E. Irish/wife Baltimore, 20b. Placa of Disposition (Neme of cemetery, cremetory or other piece) 20a. Mathod of Disposition Dete 20c. Location - City or Town, Stete 1 ☐ Buriel 2 X Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Metropolitan Crematoryl/18/00 Alexandria, VA 22. Name end Address of Facility
Arehart-Echols Funeral Home, P.A. 21. Signeture of Funerel Service Licensee M00817 dio P.O. Box 567 La Plata, MD 20646 23a. Pert1. Enter the disease, or complications that caused the daeth. Do not enter the mode of dying, such as cardiec or respiretory arrest, shock, or heen feiture. List only one cause on each line. Approximate Intervel Between Onset and Deeth Physician /Medical Immediate Cause (Final disaese or condition resulting in deeth) Small Cell Lung Cancer with metatasis to Liver Examiner Due to (or as e consequence of): Examiner that the death certificete be executed physician and the burial-trans Sequentially list conditions, if eny, leading to immadiate cause. Enter Underlying Cause (Diseese or injury that in fitted events resulting in deeth) Lest Due to (or es e consequença of): P.O. Box 68760 Physician/Medical Dua to (or as a consequenca of): 65 USB 0 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the causa of death? the ed by the 1 Yes 2 No 3 Probably 4 Unknown signed to P 24b. Were eutopsy findings evelleble prior to completion of cause of death? 24e. Wes en eutopsy Completed hes 1 Yas 1 ☐ Yas 2 ☐ No Division of Vital I director. 25. Was case referred to medical exeminer? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Othar: 4☐ Nursing Home \$ Residence 6 ☐ Other (Specify) Lo 1□ Yes ANO After this 28a. Dete of Injury (Month, Dey Year) funeral 27. Manner of Deeth 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? Certification: Hospital or Attending Neturel 5 Pending sfter death. Director: Aft 1 ☐ Yes 2 ☐ No investigetion 2 Accident 6 Could not be determined 3 ☐ Sulcide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 24 hours a **Exertifying Physician: To the best of my knowledge, deeth occurred at the time, dete end pleca, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end placa, and due to the cause(s) and mennar stated. To the Hospi within 24 hou To the Funer completely fil edicai 29a. Certifier 29d. Data signed (Month, Dey, Year) 29b. Signeture end title of certifier 29c. Licansa number D28352 JAnuary 18, 1999 30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print) Krishan Mathur, MD., 3500 Old Washington Road, Suitel02, Waldorf, MD

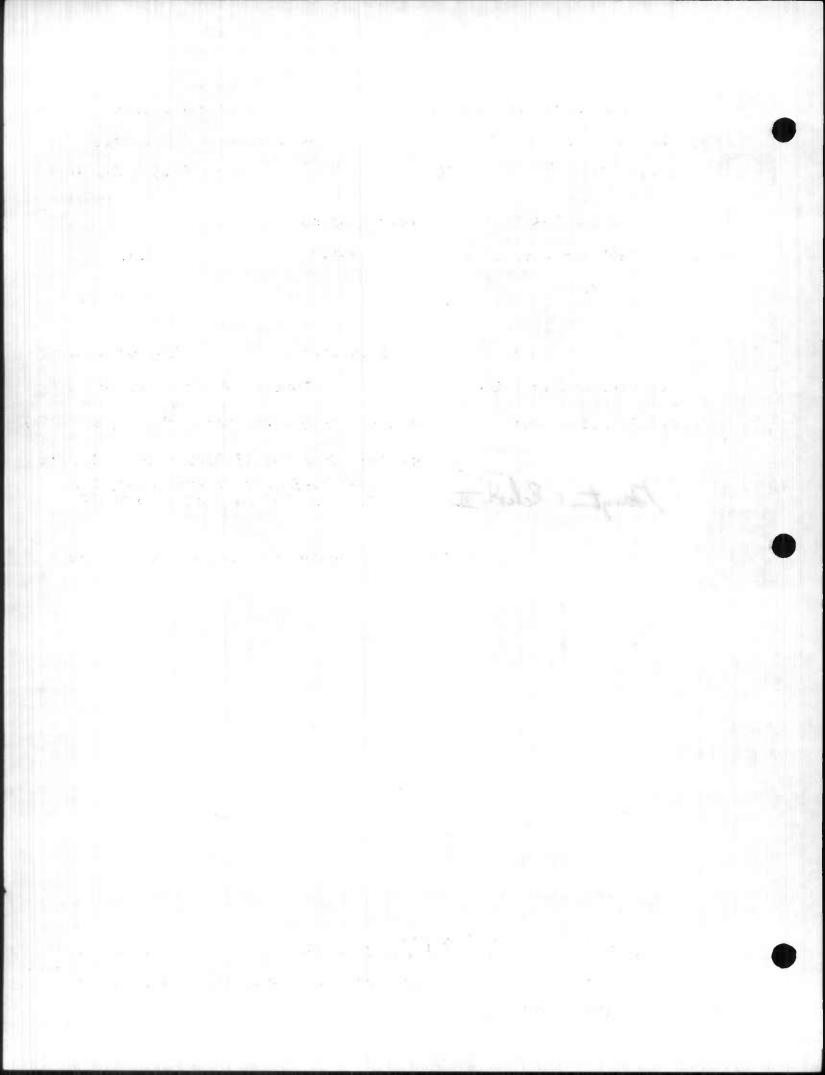
State Registrar

DHMH 16 Rev 6/95

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31. Dete filed (Month, Day, Yeer)

32. Ragistrer's Signeture Deper



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State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 1 Decedent's Name /First Middle Last) 2. Dele of Death 3. Time of Death Physician HILDA RUBY JONES 10:25 PM 14 2000 JANUARY /Medical 4b. City. Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner FROSTBURG ST. VINCENT de PAUL NURSING CENTER ALLEGANY If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) **Funeral** Days Hours 1 M 2 TF Yrs. Director JUNE 11 1900 99 MARYLAND 213-74-4292 Usual Residence of Decedeni pemit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Irriportant: If item 27 is marked other than "natural", or items 23a or 28a-f show eny injury or other treumatic event, fine Medical Examiner must be notified at enone. 10a. Stete 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 ☑ No Directo MARYLAND ALLEGANY LAVALE 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 960 NATIONAL HIGHWAY 21502 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Bleck, White, etc. 11. Maritel Stalus 1 ☐ Yes 2 ☒ No If Yes, Give 1 ☐ Never Merried 2 ☐ Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: WHITE by 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) HOME MAKER HOME MAKER 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) WILLIAM HUGHES JANE RICE 19a. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOHN R. JONES SON 960 NATIONAL HIGHWAY LAVALE, MARYLAND 21502 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremetion 3 Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) REST LAWN CEMETERY JAN 17 2000 LAVALE, MARYLAND 22. Name end Address of Fecility MERRITT-ADAMS FUNERAL HOME P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate Injervel Between Onset and Death **Physician** /Medical Immediete Cause (Finel disease or condition resulting in death) histell Examiner Due to (or es e consequence of): Examine and i-transit law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or es e consequence of): physician ar s the burial-to Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es e consequence of) 88 180 ŏ signed by the e Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown P 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed is certificate has director, page 2 The H 1 ☐ Yes 2 ☑ No 1 TYes 2 No toapital or Attending Physicien: T 4 hours after death. "uneral Director: After this certificat ely filled in by the funeral director, p 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Other: Wursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 Tes 2 No 28a. Dete of Injury (Month, Day Year) 27. Menner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury el Work? 1 Natural 5 Pending 1 Yes 2 No Investigation 2 Accident 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital or A within 24 hours after To the Funeral Director completely filled in b 1D Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete and plece, and due to the cause(s) and menner stated. 29e. Certifier Medical (Check only one) 29b. Signeture and title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) 2 JANUARY 17 2000 D 12532 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

hus

DR GEORGE BREZA

JAN 1 8 2000

State Registrar 912 SETON DRIVE

CUMBERIAND MARLYLAND

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State of Maryland / Department of Health and Mental Hygiene 11 12 2 9 2 Francine W. Jones

| | 1. Decedent's Nama (First, Mid | idia, Lasi |) | | | | Deali R. | 2. Data of Month | Reg. No. Death Day | | Yaar | 3. Tima of Death | |
|---|--|---|--|--|--|--|---|----------------------------------|--|---|---|---|-----|
| ician dical | Francine | Wo | oolford | | Jones | | | Janua | | | | 2:00 AM | |
| ner | 4a Facility Name (If not instituti | | Direction of the last | | | | 4b. City, Town, o | r Location of De | ath 4c. | County | of Death | | |
| 15 | Doro | chest | ter Genera | | - | | | ridge | | Dor | cheste | | |
| | 5. Social Security Number 212-66-1163 Usual Rasidence of Decedant | 6. Se | TM 200FE | e (In yrs. I 44 | est birthday) Yrs. | If Under 1 Yaar Months Deys | | . (Month. | Birth Day, Year) 1,195 | 55 | 9. Birthplac Country Maryla | ea (Stata or Fora ind | ign |
| Examiner mat be notified at by Funeral Director | 10a. Stata 10b. Coun Maryland Doro | | er | , | rlock | cation | | - | | | 10d | l. Inside City Limi | |
| | 10e. Street and Number 10f. Zip Coda 21643 | | | | | | 21643 | 100 | 10g. Citi | | n of What Country? | | |
| | 11. Maritel Status 1 Nevar Married 2 Me 3 Widowed 4 Divorce | | 12. Wes Decedent Armed Forcas? 1 Yas 2 1 If Yas, Giva Year or Detes: | - Settle - | | Vas Dacedent of I Yas, specify Cub | | Specify Yas or into Rican, atc.) | No- | | e - Amarican k, White, etc |). | |
| completed | 15. Decede (Specify only high | nest grad | le completed) | F.\\ | 16a. Deced (Give I lifa. D | lant's Usuel Occu kind of work dona OO NOT use retire | pation during most of w | orking | 16b. Kli | nd of Bu | siness/Indus | stry | |
| - | Elementery/Secondery (0-12) | ' | College (1-4or 5 | 0+) | Fo1 | ding To | Celes | | | este | te | | |
| | | 17. Fether's Nama (First, Middle, Lest) 18. Mother's N | | | | | | | | | a) | | |
| | Albert | nahin or | | olfor | 1 | on Address (Oc. | Ethel | Burni Barda Al | Parke | | Clate 71- C | oda) | |
| | 19e. Informant's Name/Ralation Althorias Woo | | | ter | | g Addrass (Straa oox 864, | | | | | orara, ZIP G | ude) | |
| | 20a. Mathod of Disposition | | | 20b. P | lace of Dispos | sition (Nama of | | Deta | 7 | | City or Town | n, Stata | |
| | 12 Burial 2 ☐ Cramation 4 ☐ Donetion 5 ☐ Other | n 3 🗆 F | Ramoval from Stata | | | on Cemet | | 1/14/20 | 000 F | lur1 | ock Ma | ryland | |
| | 21. Signeture of Funeral Section | | | ,,, | 22 | Nama and Addr | ess of Fecility | | 1 | | | | |
| | | | | - | _ | ennie Smale. Box 168 | | _ | | 2160 | 1 | | |
| s the bunal-transit out on the property of the | Immediata Causa (Final diseasa or condition resulting in death) a. COCAINE INTOXICATION Due to (or as e consequance of): | | | | | | | | | | | ntarval Between Inset end Death | |
| | diseasa or condition resulting in death) | | ab. | Due to (or | ras e conseq | uance of): | CATION | | | | | | |
| | diseasa or condition | { | b | Due to (or | | uance of): | CATION | | | | | | |
| | diseasa or condition resulting in death) Sequentially list conditions, if any, laeding to Immadiata cause. Enter Underlying Cause (Disease or Injury thet initiated avents rasulting in death) Last | { | d | Dua to (or | r as a consequal as a consequence a | uance of): uance of): | | | | | 0 | Inset end Death | |
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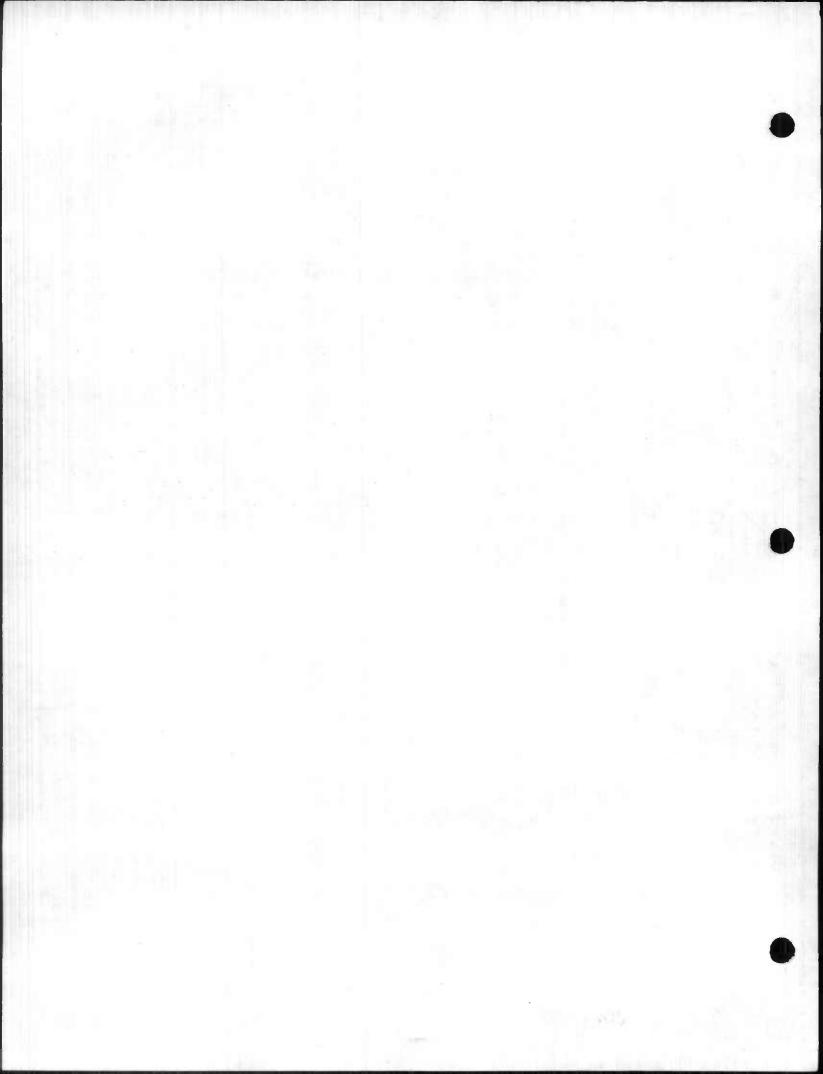
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent'a Neme (First, Middle, Last) 2. Dele of Death 3. Time of Death Month **Physician EDWARD** NELSON January **JOHNSTON** 10, 2000 1350 /Medical 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner The Memorial Hospital Easton Talbot 8. Date of Birth (Month, Day, Ye OCT 29, 1 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Yeer If Under 24 Hra. 9. Birthplece (State or Foreign **Funeral** Deys 1 XM 2 F Months Hours PENNSYLVANIA 76 Director 180-12-7424 Usual Residence of Deceden 10a. Stete 10b. County 10c, City, Town or Location 10d. Inside City Limits MD 1 Ves 2 □ No CAROLINE Directo DENTON 280-71 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 Items 23a 22320 HILLSBORO ROAD 21629 Funeral USA 14. Race - American Indian. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ⊠ Yes 2 □ No If Yes, Give Yeer or Detes: WW II Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Bleck, White, etc. 72 hours after 1 Never Merried 2 Merried 8 21215-0020 1 Yes 2 No Specify: Specify: WHITE À 3 Widowed 4 Kill ivorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) -0-SUPERINTENDENT ROAD CONSTRUCTION Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental DANIEL ADAM JOHNSTON ETHEL VIRGINIA BOWLING 19e. Informent's Neme/Reletionship (Type, Print) 19b. Melling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) TERRY JAY JOHNSTON / SON 22320 HILLSBORO ROAD, DENTON, MD 21629 20e. Method of Disposition 20b. Piece of Disposition (Neme of 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremetion 3 ☐ Removel from Stete CHESAPEAKE CREMATION CTR. 1-11-00 CHESTER, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Neme end Address of Fecility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 200 S. HARRISON ST., EASTON, MD 21601 ert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, lock, or heart failure. List only one cause on each line. Approximate Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) Examiner Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Sequentially list conditiona, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) physician the burial Box 68760 Physician/Medicai Due to (or as e consequence of): 88 USB Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yas 2 No 3 Probably 4 Unknown bengis Records. P 24b. Were eutopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy periormed? page 2 certificate 1 ☐ Yes 20 No 1 Yes 20 No Division of Vital or Attending Physicien: director. Be 25. Wes case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) edicai Certification: To 1 Yes 2 No 15 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28b. Time of 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending 1 Setural death. 1 ☐ Yes 2 ☐ No Investigation 2 Accident within 24 hours after deat To the Funeral Director: completely filled in by the 6 ☐ Could not be determined 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 3 Suicide 281. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide Hospital Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) end manner stated. 29a, Certifier (Check only one) To the 29b. Signeture and little of certifier 29c. License number 29d. Dete signed (Month, Day, Year) D009 3110 2000 30. Neme and address of person who completed cause of death (Item 23a) (Type, Print) DENNIS DESHIELDS, M.D., 219 S. WASHINGTON ST., EASTON, MD 21601 31. Date filed (Month, Dey, Year) 32. Registrer's Signeture State Registrar JAN 1 2 2000

DHMH 16 Rev 6/95

Johnston

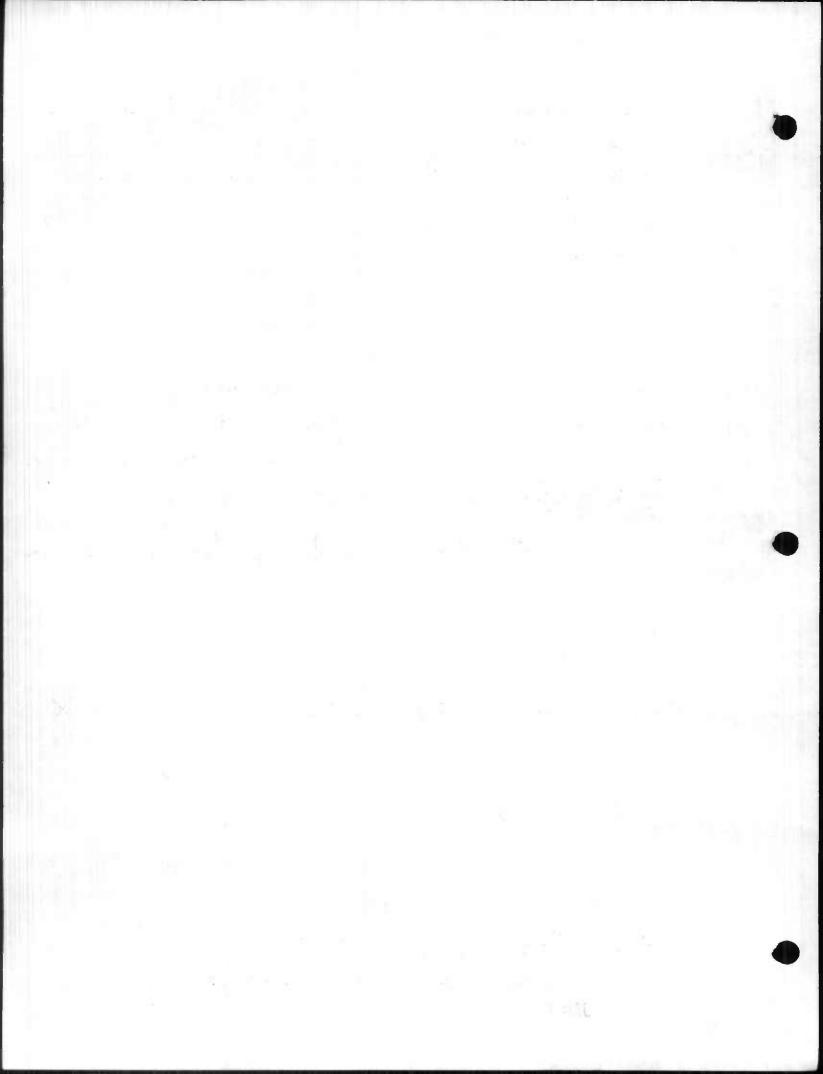
dward



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State of Maryland / Department of Health and Mental Hygiene 0 02294

| | | | | | | | | Cen | tificate of | f Death | R | eg. No. | U | . (.) 4 | |
|--|-----------------|-----------|--|-----------------------|---|----------------------------|---------------------------|-----------|---|--|---|----------------------------|--------------------------------------|--|--|
| | | | 1. Decedent's Name (First, Midd | e, Last) | | | | | | | 2. Date of Deat | h | Mari | 3. Time of Death | |
| Phys /Me | sicia: edica | _ | Ralph Willia | n Joh | nson | | | | | | Month January | Day 11 | Yaar 2000 | 1910 | |
| Exar | | _ | 4a. Facility Nama (If not institution | | | | | | | 4b. City, Town, or | _ | 4c. Count | | 1,710 | |
| | | | Kent & Quee | n Anr | ne's | Hosp | ital | | | Chestert | own | Ker | nt | | |
| Funer | rai | ٦ | 5. Social Sacurity Number | 6. Sex | | | In yrs. last bir | thday) | If Under 1 Yaa Months Day | | 8. Data of Birth (Month, Day, | | | lace (State or Foraign | |
| Direct | or. | 1 | 215-26-3847 | 11211 | A 2□ F | | 69 | Yrs. | MOTHETS Day | s Hours Min. | Dec. 22 | | | | |
| P. | | | Usual Residence of Decedent | | | | | | | | | | | | |
| anylar show | | | 10a. State 10b. County | | | 1 | Oc. City, Tow | n or Loc | ation | | | | 1 | Od. Inside City Limits | |
| Ba-f | | 2 | Maryland Kent | | | | Worton | 1 | | | | | | 1□ Yas 2√ No | |
| ith th | | Director | 10e. Street and Number | | | | | | 10f. Zip Code | | 10 | og. Citizen of | What Coun | try? | |
| 1th w 23a | | | 26620 Bigs Wo | ods R | Road | | | | 2167 | 8 | | USA | | | |
| BAIKIMOYE, MARYIANG 21215-0020 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglena. Important: if Itam 27 le marked other than "naturel", or items 23e or 28e-f show any Injury or other traumatic event, its Medical Experiment has notified at | | Dy Fur | 11. Marital Status 1 ☐ Navar Married 2 ☒ Mar 3 ☐ Widowed 4 ☐ Divorced | | . Was Dec Armed Fo 1 Tas If Yes, Gi Year or D | orcaş? 2 XNo ive | er in U,S. | | as Decedent of Yes, specify Cu □ Yas 2 🗓 No | Hispanic Orlgin? (S ban, Mexican, Puert Specify: | pecify Yes or No- o Rican, etc.) | Bla | ce - Americ ck, White, y: Blac | etc. | |
| 5-0 72 ho | | Completed | 15. Deceder | 's Educat | tion | | 16a. | Decede | ent's Usual Occi | upation | dulan | 16b. Kind of B | usiness/Inc | lustry | |
| thin the | | 2 | (Specify only higher Elementary/Secondary (0-12) | st grade c | College (| | | life. D | O NOT use retir | e during most of wor red) | king] | Local 1 | 99 | | |
| d 2121 filed within Hygiena. tither than " | | 5 | 8th | | | | | lain | tenance | | | Constru | iction | ı | |
| Maryland d 2 should be file th and Mental Hy 7 is marked othe traumatic event, | | 00 | 17. Father's Name (First, Middla, | Last) | | | | | | 18. Mother's Nar | ne (First, Middle, A | faiden Sumar | ne) | | |
| should be nd Mental marked o | | 2 | Samuel James | John | son | | | | | Lena O | . Bright | | | | |
| 2 she and and is me | | | 19a. Informant's Name/Relations | hip (Type | , Print) | | 19b | . Meiling | Address (Street | et and Number or Ru | ral Route Number | City or Town | State, Zip | Code) | |
| 1 and 27 in arm 27 in other tra | | | Betty Johnson | 1, W | life | | 2 | 2662 | O Big W | oods Road | , Worton | , Maryl | land | 21678 | |
| of He itan | | | 20a. Method of Disposition | | | | 20b. Piace of | Dispos | ition (Name of atory or other pi | lace) | Date | 20c. Location | City or To | wn, State | |
| Pagas nant of P int: if its | | | 1 N Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (5 | | noval from | Stata | | | | | 1/15/00 | Vorton | Big V | Woods) Md. | |
| baltimore, permit. Pagas 1 ar Department of Haa Important: if Item; any Injury or other | 8 | 1 | 21. Signature of Funeral Service | Licensee | | | | | Name and Add | | | | 0 | | |
| n ages | once. | | Bennie Smith Funeral Home | | | | | | | | | | 0.1 | | |
| | | + | P.O. Box 1687, Easton, Maryland 21601 23a. Part Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, Interval Between Interval Between | | | | | | | | | | | | |
| Physicia /Medica Examine | al | | Immediate Ceuse (Final disease or condition resulting In death) | e | Sm | ell | C e | 11 | Caro | inoni | - un | know | 2 | Interval Between Onset and Death | |
| 70 .5 | | <u> </u> | | | | | (5, 55 5 | | | | | | | | |
| rifficate be axecuted ng physician and as the bunal-transit | - Landard | | Sequentially list conditions, | 1 b | | Du | e to (or as e | consequ | ence of): | | | | | | |
| e axe | ú | | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | | | | | | | | | | | | |
| ficata be au physician to the buria | Madioal | | Cause (Disease or injury that initiated events c | | | | | | | | | | 1 | | |
| ing p | | | | | | | | | | | | | | | |
| ath cert ath cert intendin | 100 | | | Q | | | | | | | | | | | |
| the all | 0.0 | 2 | Part I. Other aignificent condition | ns contrib | outing to d | leath but I | not rasulting Ir | tha und | darlying cause g | given In Part I. | 23b. Did to | becco uee co | ntribute to | the cause of death? | |
| S, T. Is that the | hy Dhyelelan | 6 | Non insulia | de | rend | ent | dial | if | mel | liku | 1 🗆 Yı | 2□ No | 3 Prot | ably 4 Unknow | |
| na law require thas been signal of a | Completed | 2000 | | | J | | | | | | 24e. Wes er perform | n eutopsy ned? | ava cos | re eutopsy findings tilable prior to npletion of cause death? | |
| The law ate has page 2 | 1 | 5 | | | | | | | | | 1 □ Ye | s a No | 1 🛭 | Yes 2□ No | |
| ysician: Tha is s cartificata he director, paga | 00 | | 25. Was case referred to medice exeminer? | | | | | | | 26. Place of Dee | th (Check only on | 9) | | | |
| Physical this can rail direction | 1 | | 1 Yes 2 No | Hos | pital: | Inpatient | 2□ER/Ou | tpatient | 3□ DOA O | ther: 4 \(\text{Nursing H} \) | ome 5 Reside | nce 6 🗆 Oth | ner (Specif) | <i>'</i>) | |
| ng Ph Tharth | | | 27. Manmer of Death 1 Natural 5 ☐ Pendir | | 28a. Date (Mon | of Injury | 'ear) 28b. 1 | ime of | 28c. Inj | ury at ork? | 28d. Describe ho | w Injury occur | red | | |
| andir on A | 100 | | 2 Accident investi | ation | | | | | | Yes 2□No | | | | | |
| UNITED THE HORPITAL OF THE HORPITAL OF THE CHARLES OF T | Cortification | | 3 Sulcide 6 Could 4 Homicide determ | | 28a. Piace buildi | a of Injury ing, etc. (| - At home, fa Specify) | rm, stree | et, factory, office | a | 28f. Location (Sti City or Town | | ber or Rura | l Route Number, | |
| Fo the Hospital within 24 hours To the Funeral completely filled | Indical | | 29a. Certifier (Check only one) Certifylr (Check only one) | g Physici Examiner | : On the b | best of reasis of ex | camination and | , death o | occurred at the estigation, in my | time, dete end place opinion, death occu | , end due to the ca rred at the time, da | use(s) end mite and place, | enner as st and due to | eted. the cause(s) | |
| Fo the Ho within 24 To the Fu complete | Me | | 29b. Signature and title of certifie | - | > | | | | 29c. Licar | nsa number | 29 | d. Date sign | d (Month) | Day, Year) | |
| | | | 1600 | (| 0. | 0 - | | n 5 | DI | 6494 | | 1/ | 13/ | 2000 | |
| | | | 30. Name and address of person | who come | oleted calu | se of deal | th (Item 23a) | | | 1 | | 1 | -1- | | |
| | | | Lavno D (? | 20 1 | ah | 1 | mn | · ypo, r | Chos | Fertons | n M | X 2 | 16 | 20 | |
| | State | | 31. Date filled (Month, Dey, Year) | 16 | 2000 S | Registrar's | Signature | 1 | 4 | barr | 4 | | | | |



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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician LOUIS SYLVESTER JOHNSON, JR. 01 ĩi 2000 12:39 AM /Medical 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGE'S GREATER LAUREL REGIONAL HOSPITAL LAUREL If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, Year) June 6, 1953 5. Sociel Security Number 7. Age (In yrs. lest birthdey) 9. Birthplaca (State or Foreign **Funeral** Months Davs Min Hours 1 XM 2 F Maryland 220-56-5875 46 Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. fnside City Limits 1) Yes 2□ No Maryland Directo Prince George's Laurel 28a-f must be notifi 10e. Street and Number 10f Zip Code 10g, Citizen of What Country? Harrie 23a or 20707 14918 4th Street U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 k Yes 2 □ No If Yes, Give Yeer or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Maritai Status Black, White, etc. 1₺ Never Merried 2 Married 8 Baltimore, Maryland 21215-0020 1 Yes 2 No Specify à 3 ☐ Widowed 4 ☐ Divorced Black "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Auto Mechanic Private 12th marked other 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Nt. Payes 1 and 2 should be artment of Health and Mental 1 ortant: If them 27 is marked of Louise Sylvester Johnson, Sr. Mary V. Brooks 19a. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary V. Brooks/Mother 4906 Collington Road, Bowie, Maryland 20715 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremetion 3 ☐ Removel from State Maryland Veterans Cemetery 2000 4 ☐ Donetion 5 ☐ Other (Specify) Cheltenham, Maryland 21. Signeture of Funeral Service Licensee J. B. JENKINS FUNERAL HOME 7474 Landover Road, Landover, Maryland 20785 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feiture. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** Immediete Cause (Finel disease or condition resulting in deeth) /Medical MYOCARDIAL INFARCTION Examiner Due to (or as a consequence of): Examiner ISCHEMIA HEART DISEASE YEARS physician and s the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initieted events resulting In death) Last Due to (or as e consequence of): DIABETES MELLITUS 9 YEARS Box 68760. edical Due to (or as a consequence of): Physician/M 980 0 Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? Records. P.O. the signed by t 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown by 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? Deen page 2 certificate has 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vitai 25. Was case referred to medical axaminer? Be 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 8 Other (Specify) To 1 ☐ Yes 2 🛣 No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Dete of Injury (Month, Dey Year) 27. Menner of Death 28b. Time of fnjury 28d. Describe how injury occurred Certification: 28c. Injury at Work? After 1 XNetural Attending 5 Panding investigation or Attending after death. Director: After 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stele) 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 24 hours a Funeral D Hospital Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) and menner stated. edical 29e. Certifier (Check only one) To the F \$ 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) an 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hopkins Haspital -

State Registrar

DHMH 16 Rev 6/95

Johns

32. Registrer's Signeture

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31. Date filed (Month, Dey, Year)

JAN 1 4 2000

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Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene | | Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Deeth **Physician** 01 SUSIE 10 M. 2000 5:45 PM **JACKSON** /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner PRINCE GEORGE'S HOSPITAL CENTER CHEVERLY PRINCE GEORGE'S If Under 1 Year If Under 24 Hrs. 5 Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Min 1 M 2 F Months Days Hours 128-20-4127 83 February 2, 1916 South Carolina Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Menyland neat of Health and Mentle! hygiene. In the merked other than "neture!", or ferme 23a or 28a-f show int: if fear 25 is marked other than "neture!", or fear 25a or 28a-f show ury or other traumetic event, the Medical Experiment must be notified at 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No Directo Maryland Prince George's Mitchellville 10e. Street and Number 10f. Zip Code 10g. Citlzen of What Country? 1202 Kings Tree Drive 20721 U.S.A. Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: Black. à 3 X Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Nurse's Aide 12th Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Lawrence Keels Vinnie Oliver 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Lepartment of Health en important: If Item 27 Is n eny Injury or other Pace. Linda Jackson-Jones/Daughter 1202 Kings Tree Drive, Mitchellville, Maryland 20721 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 01/15 1 Burial 2 Cremation 3 Removal from State Pine Lawn Cemetery 2000 4 ☐ Donetion 5 ☐ Other (Specify) Melville, New York 21 Signature of Funeral Service Licensee J.B. JENKINS FUNERAL HOME Name A. Ercente 7474 LANDUVER RUAD, 23a. Part1. Enter the integral passes, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 7474 LANDOVER ROAD, LANDOVER, MARYLAND 20785 Approximete Interval Between Onset and Death Physician /Medicai Immediate Cause (Final disease or condition resulting in death) Examiner Due te Examiner The law requires that the death certificate be executed physicien and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last O. Box 68760. Physician/Medical Due to (or as a obnsequence of): attending p signed by the a 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert f. 2 3 Probably 4 Unknown p Records, 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy Completed peeu hes he 2 page 1 Yes 2 No 1 Yes certificete nuc Division of Vital 25. Was case referred to medical examiner? or Attending Physician: director, Be 26. Plece of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this After thi funerei Date of Injury (Month, Day Year) 27. Menner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury Natural 5 Pending 1 Yes 2 No death. 2 ☐ Accident investigation ofter death Director: A In by the f 6 Could not be determined 3 Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Funersi Dire Hospital 24 hours 29a. Certifier 🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end place, and due to the cause(s) and manner es stated Medicai 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steled. (Check only one) To the Within 2 To the 29d. Date algned (Month/Day, Year) 29b. Signature and title of certifier 29c. License number erre 30. Name and aggress of person who completed cause of death (Item 23a) (Type, Print) JAMES CATAVENIS, M.D. 3001 Hospital Drive, Cheverly, Maryland 20785 31. Date filed (Month, Day, Year)

JAN 1 2 2000 32. Registrar's Signature

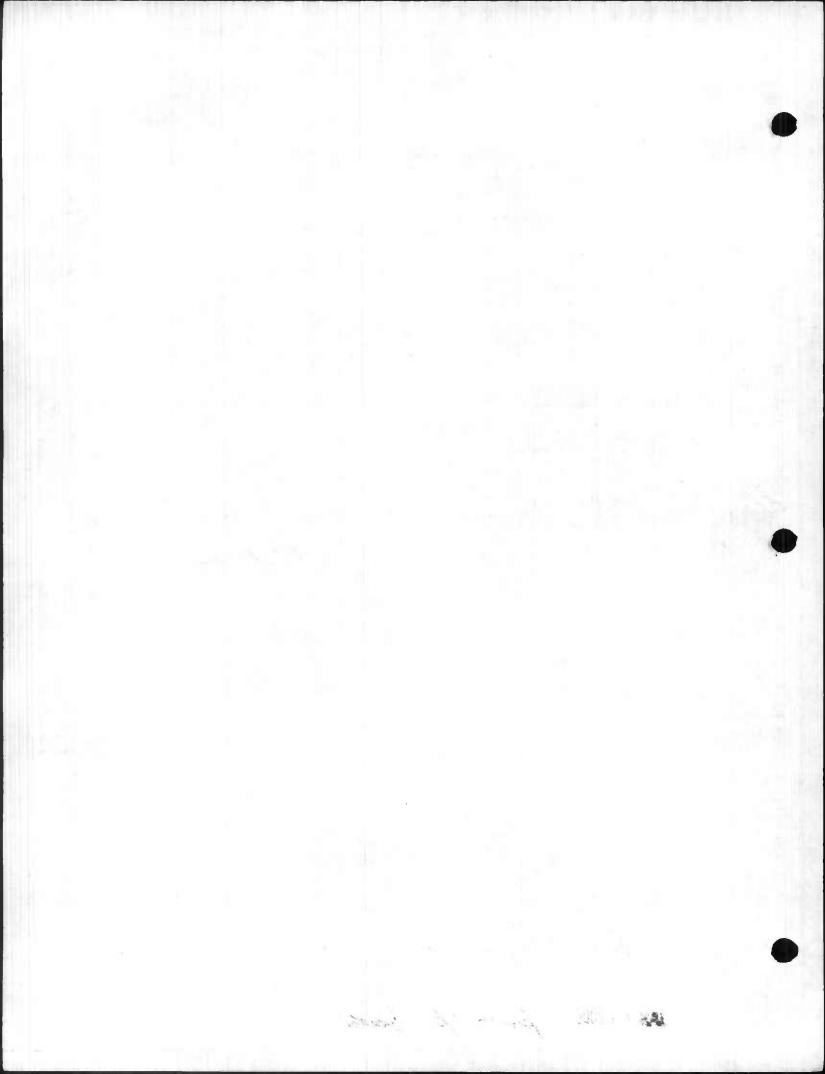
DHMH 16 Rev 6/95

State Registrar

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| | Certificate of Death | Reg | 110 | 12297 | | |
|--|--|-------------------------------------|-------------------------------------|---|--|--|
| Physicia | Decedent's Name (First, Middle, Last) | 2. Date of Death Month | Day Year | 3. Time of Death | | |
| Physiciar /Medica | loseph Shellon Jacob, Sr. | | 6, 2000 | 3:46 p.m. | | |
| Examine | Ab City Town or I o | ocation of Death | 4c. County of Death | 1 | | |
| | Calvert Memorial Hospital Prince Fre | ederick | Calvert | | | |
| Funeral | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. | 8. Date of Birth (Month, Day, Yo | 9. Birth | oplace (State or Foreign untry) | | |
| Director | 577-42-6562 110 M 2 F 66 Yrs. Months Days Hours Min. | May 3, 1 | 933 Was | hington, DC | | |
| P | Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location | | | 404 5-14-05-11-5- | | |
| anyla ahon | | | | 10d. Inside City Limits 1 ☑ Yas 2 ☐ No | | |
| vith the Ma | Maryland Prince George's College Park | | | | | |
| ti o d | | | . Citizen of What Cor | untry? | | |
| 23 ath | 5905 Osage Street 20740 | | S.A. | ione Indian | | |
| 21215-0020 d within 72 hours after death with the Maryland glene. If then "natural", or herns 23a or 28ad show if the Maryland at the modified at the modifie | 3 ☐ Widowed 4 ☐ Divorced Year or Dates: | Rican, etc.) | Black, White | | | |
| 1 21215-002 led within 72 hours tyglene, metural, rt, the Header | 15. Decedent's Education 16a. Decedent's Usuel Occupation | 16 | b. Kind of Business/I | ndustry | | |
| | (Specify only highest grade completed) (Give kind of work done during most of work life. DO NOT use ratired) Elementary/Secondary (0-12) College (1-4or 5+) | W. | ashington | , DC | | |
| | Metropolitan Police Off | Ficer P | olice Depa | e Department | | |
| be filed within that Hygiene. If other than event, the H | 17. Father's Name (First, Middle, Last) 18. Mother's Name | e (First, Middle, Me | iden Sumame) | | | |
| Maryland 2 d 2 should be filled v th and Mental Hygie the marked other traumatic event, in | William F. Jacob, Jr. Elizabeth | n Norris | | | | |
| - 0 0 T = | 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Ruri | | | | | |
| | Patricia A. Jacob - Wife 5905 Osage Street, Col | | | | | |
| nore, ges 1 an it of Heal if item 2 or other | 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, cremetory or other place) | Date 20 | c. Location - City or 1 | rown, State | | |
| Saltimor | 4 □ Donetion 5 □ Other (Specify) MD National Memorial ParkO | 1/10/00 La | urel, Mar | yland | | |
| Baltimore, permit. Peges 1 ar peperin or of Hea moorant: If item any injury or other page. | 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gasch's Funeral Hor 4739 Baltimore Aver | | teville l | MD 20781 | | |
| | 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac of shock, or heart feiture. List only one cause on each line. | | | Approximata Intervai Between | | |
| Physician /Medical | Immediate Ceuse (Final disease or condition resulting in death) a. Convy Aniony Due to (of as a consequence of): | 1082 | | | | |
| dS, P.O. BOX 58/50, ires that the death certificate be executed signed by the estending physician and die detached for use as the burial-transit the Development of the period of the control of the cont | | | | | | |
| at the death certification of the estending estached for use a | | 1 | | | | |
| at the de by the estached | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | to the cause of death? | | |
| That that detail | | 1 404 | 21 No 31 PF | obably 4 N Unknown | | |
| aw raqu | | 24a. Was an a performe | d? | Wera autopsy findings evailable prior to completion of cause of death? | | |
| | | 1 🗆 Yes | 2 🕅 No 1 | ☐Yes 2☐ No | | |
| Action: The contilicate rector, pag | | h (Check only one) | | | | |
| Of VITA Physicien: this certificial director, | | me 5 Residence | e 6 Other (Spec | city) | | |
| Affect of the state of the stat | | 28d. Describe how | injury occurred et and Number or Ru | iral Douta Number | | |
| Urs after or A ster illed in by | 4 Homicide 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) | City or Town, S | State) | | | |
| To the Hospital or Attend within 24 hours after death To the Funeral Director; completely filled in by the | 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, control one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, control one) 1 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, control one) | red at the time, date | and plece, and due | to the cause(s) | | |
| Total | 29b. Signature and this of certifier 29c. License number | . Date signed (Month | n, Dey, Year) | | | |
| | 1 muc 1444 mm D26382 | J | anuary 7, | 2000 | | |
| (20) | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) | | | | | |
| (0) | Marc R. Shepard, M.D. 4700 Berwyn House Road 3105, | College | Park, MD | 20740 | | |
| State Registrar | 31. Date filed (Month, Day, Year) 32. Registrar's Signeture | | | | | |

DHMH 16 Ray 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death 5:55 a.m Month Yea **Physician** Harry Jackson, Jan 2000 /Medical 4a Facility Name (If hot institution, give street and number) 4c. County of Deeth 4b. City, Town, or Location of Death Examiner Hospital. Bethesda If Under 24 Hrs. 8. Date of Birt Suburban Montgomery

9. Birthdece (State or Foreign
Country) 5. Social Security Number 6. Sex If Under 1 Year 8. Date of Birth (Month, Day, Year) **Funeral** Months Min. 1 M 2 F Days Hours 578 48 9740 62 Yrs. Director Oct. 26 1937 Wash DC Usual Residence of Decedent 10a. State 10c. City, Town or Location 10h Counh 10d. Inside City Limits pernit. Pages 1 and 2 should be filed within 72 hours effer death with the Marylan Department of Health and Menia! Hygiens. Important: if item 27 is marked other than "natural", or itema 23a or 28a-f show any injury or other traumatic avent, the Medical Exercises must be notified at onds. 1 Yes 2□ No Montgomery Director MD. 10e. Street and Number 10g. Citizen of What Country? 20904 USA Paralle Lane 2201 12. Was Decedent Ever in U,S. Armed Forces?

1 Yes 2 No II Yes, Give Year or Dates: 14. Rece - American Indien, Bleck, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0020 Specify: Negro. by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Saleman 12 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Carol C Jackson Wallace 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10e, c, b, a, Patricia Same as: f. N. Jackson 20b. Place of Disposition (Name of cometery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 (Burial 2 Cremetion 3 Removal from State 4 Donation 5 Other (Specify) Silver Spring, Gate of Iteaven 111/00 22. Name and Address of Facility 21. Signature of Funeral Service Licens Company John T. Rhines 23a. Perty Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Wash DC 20017. Approximete Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Congestive Heart Failure Examiner Cardio-myopath Physician/Medical Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 555 AM Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Diabetes Mellitus 24b. Were autopsy findings available prior to Completed 24a. Wes an autopsy performed? Stroke. completion of cause of death? Harry Jackson, 1 ☐ Yes 2 No 25. Wes case referred to medical axaminer? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: 5 Pending investigation 1 Yes 2 No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Cartifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D38262

DHMH 16 Rev 6/95

Registrar

30. Name and address of person who completed cause of de

Anurita

31. Date filed (Month, Day, Year)

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ath (Item 23a) (Type, Print)

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2401 Research Blvd. Rockville MD. 20850

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** Month Alvena Marie Johnson 2000 8:15 PM January /Medical 4e. Facility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner 619 Admiral Dr. 202 Annapolis Anne Arundel 5. Sociei Security Number If Under 1 Yeer If Under 24 Hrs. Hours Min. 8. Dete of Birth (Month, Dey, Year) Aug. 10, 1920 7. Age (In yrs. lest birthday) Birthplece (Stete or Foreign Country) Funeral 10 M 20 F Deys Yrs. 79 Director 511-18-9722 Kansas Usuel Residence of Decedent the Maryland 10e Stete 10b. County 10c. City, Town or Location 10d. tnside City Limits "natural", or items 23e or 28a-f show Director 1 ☐ Yes 2 No Anne Arundel Annapolis 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? #202 619 Admiral Dr. Funeral 21401 USA death 12. Was Decedent Ever in U,S Armed Forces? 11. Maritel Stetus 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bieck, White, etc. filed within 72 hours after 1 □ Never Married 2 □ Married 1 Yes 2 No If Yes, Give Year or Dates: 21215-0020 1 Yes 2 No Specify: Specify: White þ 3 X Widowed 4 Divorced Completed the Medical 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grede completed) I Hygiene. Elementery/Secondery (0-12) Coliege (1-4or 5+) Secretary School 1 marked other traumetic event. Baltimore, Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be Pages 1 and 2 should be nent of Health and Mental Andrew Wiberg Hul da Duval1 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 69 of Health of Hem 27 I Gail Andrews / daughter 7726 Willow Pt. Dr. Falls Church, Va. 22042 other 20a. Method of Disposition 20b. Piace of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 1 Buriel 2 □ Cremetion 3 □ Removel from State = 6 Department of Important: If any injury or once. 1-13-00 4 ☐ Donetion 5 ☐ Other (Specify) St. Paul's Cemetery Garrison, S.D. 22. Name end Address of Fecility John M. Taylor Funeral Home, Inc 21. Signeture of Funeral Service Licensee 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or hear feilure. List only one cause on each line. **Physician** /Medical 4 mos Immediate Cause (Final Cholangiocavainouna disease or condition resulting in deeth) Examiner Examiner The law requires that the death certificate be executed Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initieted events resulting in deeth) Last the burial-tran Due to (or es e consequence of): P.O. Box 68760. physician Physician/Medical Due to (or es e consequence of): USe as lor Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown eigned by 1□ Yes 2NNo Division of Vital Records. þ page 2 should be 24b. Were autopsy findings avellable prior to completion of cause of death? Completed 24e. Wes an autopsy performed? peen certificata has I 1 🗆 Yes 1 ☐ Yes 2 ☐ No Physicien: Be 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) examiner Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
Injury et 28d. Describe how injury occurred Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 2 this 27. Menner of De 28e. Dete of injury (Month, Dey Year) 28c. Injury et Work? Certification: 28b. Time of Affer or Attending 1 Naturel 2 Accident 5 Pending investigation after death. 1 Yes 8 Could not be 3 ☐ Suicide In by t 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide 24 hours e Hospital Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occurred et the time, dete end piece, and due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date end piece, end due to the ceuse(s) end menner stated. completaly (Check only one) Within To the 29b. Skinature and 29c. License number 29d. Date signed (Month, Dey, Yeer) 1/7/2000 30. Name and eddress of person who completed cause of deeth (Hem 23e) (Type, Print) of Bestgare Rd. Annapolis, und. 21401 Strart E. Selouian, und 900 Bestgare Rd. Annapolis, und. 21401

State Registrar 31. Dete filed (Month, Day, Year) JAN 1 1 2000

32. Registrer's Signeture

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 2300

| | | | Cen | tificate of | Death | | Reg. No. | |
|---|---|--|------------------------|--|---|--|--|--|
| | 1. Decedent's Neme (First, Middle, Last |) | | | | 2. Dete of D | | 3. Tima of Death |
| Physician /Modica | (7(7) 17) 17 17 | OHNSON | | | | JAN. | 13 2000 Yes | 1330 |
| /Medica Examine | An English Manne // met le etitudes miss | street and number) | | | 4b. City, Town, o | or Location of Deal | th 4c. County of De | eeth |
| | ANNE ARUNDEL MI | EDICAL CENTE | ER | 7 | ANNAPOL | TS | ANNE AR | UNDEL |
| Funeral | 5. Social Security Number 6. Se | x 7. Age (In yrs. | | If Under 1 Yaar Months Deys | Hunder 24 H | rs. 8. Dete of Bi | | Birthplace (Stata or Foreign Country) |
| Director | 213-34-3452 Usuel Residence of Decedent | ом 2 0 F 65 | Yrs. | Months Days | Hours M | OCT. 1 | 8 1934 M | ARYLAND |
| pue & m | 10e. Stete 10b. County | 10c. City | y, Town or Loc | ation | | | | 10d. Inside City Limits |
| vith the Mery | MARYLAND ANNE AL | RUNDEL ANN | NAPOLI | T | | | | 1 ☐ Yes XIXNo |
| A South | 10e. Street and Number | | | 10f. Zip Code | | | 10g. Citizen of What | |
| f 23 | 18 WASHINGTON I | | 2140 | | | USA | | |
| d within 72 hours after deeth with the Menyland jene. It than "natural", or flame 23s or 28s-f show the Widel Eventher The Monthleted his Entered Director. | 11. Marital Status 1 Never Married 2 Merried 3 Widowed 4 Divorced | 12. Was Decedent Ever in U, Armed Forças? 1 ☐ Yas 2 No If Yes, Give Yaar or Datas: | H | /as Decedent of F Yes, specify Cub- ☐ Yes 2 X No | dispanic Origin? an, Mexican, Pu Specify: | (Specify Yas or Netro Rican, etc.) | Bleck, W | nerican Indian, hite, etc. BLACK |
| nartural', | | | 16a. Decede | ent's Usual Occup | ation | | 16b. Kind of Busina | ss/Industry |
| ed within 72 ho ygiene. we than "natur ft, the Medical | (Specify only highest grad | le completed) College (1-4or 5+) | (Give k | ind of work done O NOT use retire | during most of v d) | vorking | CROMNENT | LLE STATE |
| filed within I Hygiene. | 12th | 0 | PSYCH | IATRIC | AID | | HOSPITAL | |
| be filed tel Hygid d other event, the | 17. Father's Name (First, Middle, Last) | | | Die St | 18. Mother's N | leme (First, Middle | , Meiden Sumeme) | OBIN + BIN |
| should be ad Mentel marked o matic ev | OLIVER HUDSON | | | 3.5 | BES | SSIE WII | LLIAMS | |
| 2 2 2 2 | 19a. Informant's Neme/Retetionship (7) JOSEPH D. JOHNSO | | | | | | per, City or Town, State | |
| s 1 and f Health frem 27 other tr | 20a. Method of Disposition | ` ' | liece of Dispos | | | Dete | 20c. Location - City | |
| 0 0 - 2 | Buriei 2 ☐ Cremetion 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) | Removal from Stata | emetery, crem | VETERA | | | | NSVILLE, MD |
| pemit. Peg Department Important: t eny injury o | 21. Signeture of Funaral Service Licens Harry 1 | Leese | 22. WM 82 | | E & SON | | JARY, P.A | |
| | 23a. Part1. Entar the diseese, or complishock, or heert failura. List only or | ications thet causad tha death | | | | | | Approximete Intervel Between |
| /Medical Examiner | Immediete Causa (Final disease or condition resulting in deeth) | Due to (o | stat r es e consequ | eance of): | Cane | 4 | | |
| ortificate be executed fing physicien and see the buniel-transit | Sequentially list conditions, if any, taading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | C | r es a consequ | | | | | 1 |
| ding ding | | db. | | | to the | | | |
| deeth deeth defor u | Post II Other clanificant conditions are | to to the source of death 9 | | | | | | |
| | Pert II. Other significant conditions cor | ntributing to death but not rest | | 23b. Did tobacco use contribute to the cause o | | | | |
| s that es that good be determed by Pl | | _ ' | 2010 | | | | | |
| requir been should | | | | | | | s en eutopsy ormed? | b. Were autopsy findings available prior to completion of causa of death? |
| 0 5 5 | | | | | | | Yas 2 No | |
| ician: The certificate rector, pag | | | | | | | | 1 Yes 2 No |
| | | lospitel: | 5D40 10-45-11 | all post Oth | er _ | Deeth (Check only | | |
| 2 2 2 | | 28a. Data of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injui | 4 🗆 Nursing | | idence 6 Other (S how injury occurred | pecify) |
| or Attendent there death or Attendent in by the striffical artiffical | 2 Accident investigation 3 Suicide 6 Could not be datarmined | 28e. Piece of Injury - At ho building, etc. (Specify | | | 165 2 110 | 28f. Location City or To | (Street end Number or wn, Stete) | Rural Route Number, |
| Hospi 24 hou Funer (ely fill | | sician: To the best of my knowner: On the basis of axaminet and menner stated. | wledge, deeth o | occurred et the tirestigetion, in my o | me, date end pla pinion, death oc | ice, end due to the courred at the time | causa(s) and mannar data and place, and d | as stated. dua to the cause(s) |
| within 2 To the comple | 29b. Signatura and titla of certifier | 1 | | 29c. Licens | e number | | 29d. Data signed (Mo | onth, Day, Year) |
| F 3 F 8 | 1 - 1 | 11 ~ 14 | Λ | DE | 2711 | | 1 1 | |
| | Curlin / | Jana M. | 0. | 1/7 | 1,00 | | 1171 | |
| | 30. Name and address of person who co | - mn la | 23a) (Type, P | rection . C | we h | inte 23/ | anapolis | MD 21409 |
| State Registrar | 31. Dete filed (Month, Dey, Year) | 32. Registrer's Signer | Jura & | Spar | Kel | | | |

DHMH 16 Rev 6/95

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Piease Type or Print in Biack indelible ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Jan 2000 Everett Junior Knight

3. Time of Death

10d. inside City Limits 1 ☐ Yes 2 ☑ No

21784

Approximate Intervel Between Onset and Death

24b. Were autopsy findings available prior to

completion of cause of death?

1 ☐ Yes 2 ☐ No

Virginia

White

9:15 PM

Physician /Medical Examiner

4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Woodbine Carroll 7015 Woodbine Road If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Hours 1⊠M 2□F 67 Yrs. 218-28-0067 20, 1932 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important if from 27 is marked other than "natural", or florms 23s or 28s-f show any Injury or other traumatic avent, from Medical Examinet must be notified. 10a State 10b. County 10c. City, Town or Location Directo Maryland Carroll Woodbine 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7015 Woodbine Road 21797 United States Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Raca - American Indian Black, White, etc. 1⊠Yes 2□No 1953— If Yes, Give Year or Dates: 1955 1 □ Never Married 2KI Married 1 ☐ Yes 2 XNo Specify: Specify: p 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondary (0-12) College (1-4or 5+) Superintendent Charles H. Riddle Co. 8th 18. Mother's Name (First, Middle, Maiden Surneme) 17. Father's Name (First, Middle, Last) Be Morris Everett Knight Cigourney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 21797 Helen Marie Knight Wife 7015 Woodbine Road Woodbine, MD 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 1/17/2000 Sykesville, MD Lake View Memorial Park 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Burrier-Queen Funeral Directors, P.A. veus 1212 W. Old Liberty Road Winfield, MD Part1. Enter the disease, or complications that cause the leath. Do not enter the mode of dying, such as cardiac or respiretory errest, shock or heart fellure. List only one cause on each in **Physician** /Medical immediate Cause (Final Multiple injuries due to MVA disease or condition resulting in death) Examiner MA MEDICAL EXAMINES Due to (or es e consequence of): Examiner and I-transit The law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to for as a consequence of: physician a the burial-Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): 88 signed by the a Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Sepsis à 24a. Was an autopsy performed? Completed s certificate has director, page 2 1 ☐ Yes 2 ☒ No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 🖾 Residenca 6 ☐ Other (Specify) 2 1⊠ Yes 2□ No this funeral 28a. Dete of Injury (Month, Dey Year) Apr 9, 1999 28b. Time of 28d. Describe how Injury occurred 27. Manner of Death Certification: 28c. Injury at Work? 8:30 A M 5 Pending s after de. 1 Neturel 1 Yes 2⊠No Pedestrian struck by auto Investigation 21 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital or A within 24 hours aftar To the Funeral Direcompletely filled in b Woodbine Road street 29a. Certifier 🕱 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated. edicai (Check only one) 2 Medical Examiner: On the basis of examination and/or investigetion, in my opinion, death occurred at the time, date and piece, and due to the cause(s) end manner stated.

29b. Signature and title of certifiq 29d. Date signed (Month, Day, Year) 29c. License number D25443 January 13, 2000 30. Name and address of person who completed ceuse of deeth (Item 23a) (Type, Print) 688 Poole Road Westminster, MD John W. Middleton 31. Date filed (Month, Dey, Year) 32. Registrar's Signature State JAN 1 8 2000 Registrar

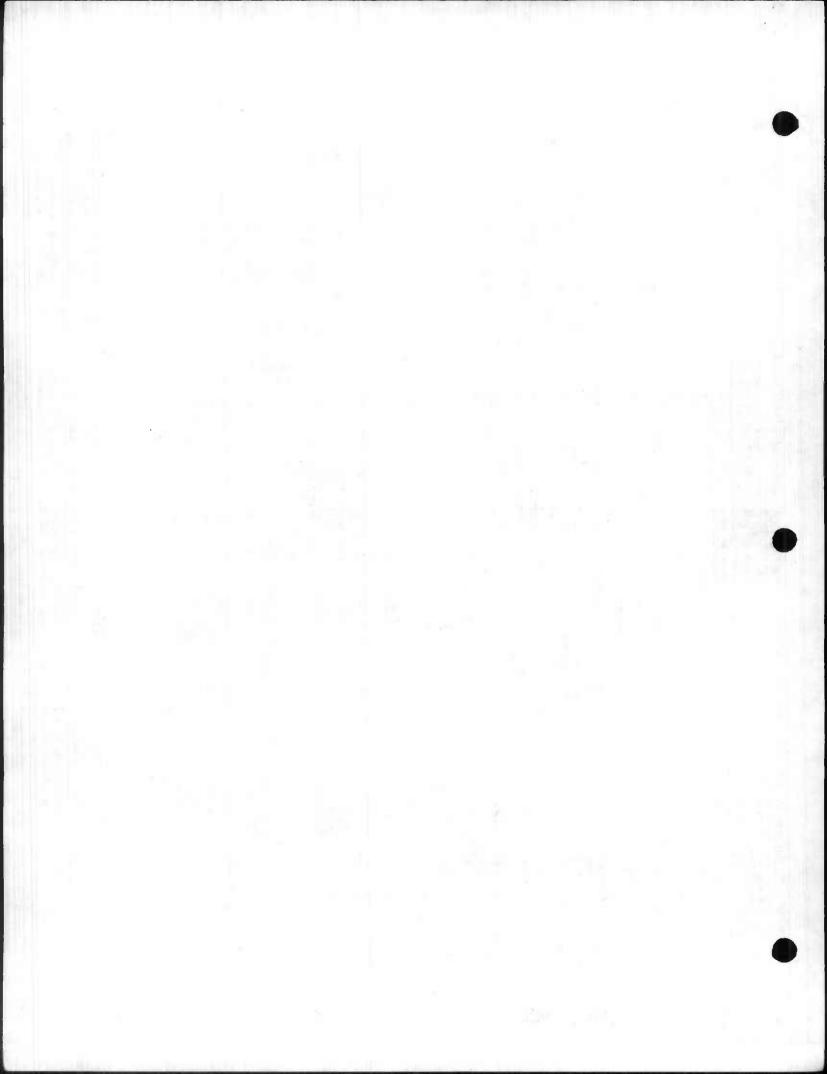
0005 8 1 MAG

Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

| | | | Cert | ificate of | Death | , | Reg. No. | 0 0 | 2200 |
|---|---|--|--|--|--|--------------------------------------|-----------------------------|---------------------------------|---|
| Physician | Decedent's Name (First, Middle, Last |) | | | | 2. Dete of Do Month | Day | Year | 3. Time of Death |
| /Medical | James Alva Keys | | | | | | | 2000 | 6:A.M |
| Examiner | 4a Facility Name (If not institution, give | • | | | 4b. City, Town, or L | | | | |
| | CIVISTA MEDICAL | | | | LAPLATA | | | HARLE | |
| Funeral Director | 5. Social Security Number 6. Se 127-44-6165 Usual Residence of Decedent | 7. Age (In yr 56 | rs. last birthday) Yrs. | If Under 1 Year Months Days | | 8. Date of Bi (Month, Di Sept. | rth ey, Year) 2, 1943 | 9. Birthpla Countr Mary 1 | ace (State or Foreign y) and |
| show show of all | 10a. State 10b. County | | City, Town or Loca | ition | | | | 100 | d. Inside City Limits |
| rith the Ma or 28a-f s be notified Director | Maryland Charles | l N | Janjemoy | | | | | | |
| | 10e. Street and Number 10855 Rising Sun F | Place | | 10f. Zip Code 20662 | | | U.S.A. | | у? |
| 5-0020 72 hours after death virtues; or fleme 2a scal Examiner must | 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. Wes Decedent Ever in Armed Forces? 1 Yes 2 No 1 If Yes, Give Year or Dates: 1 0 | 965- | as Decedent of res, specify Cut | Hispanic Origin? (Sp ban, Mexican, Puerto Specify: | pecify Yes or No Rican, etc.) | 14. Rac Ble Specifi | ck, White, et | ic. |
| | 15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) | cation le completed) College (1-4or 5+) | 16a. Deceder (Give ki | nt's Usual Occu nd of work done O NOT use retire | pation during most of work ed) | king | 16b. Kind of B | usiness/Indu | istry |
| 1 2121 1 2121 1 2121 1 2121 1 1 1 1 1 1 | 12 | | Propel | lant Ha | ndler | | U.S. G | overn | ment |
| and does the servent | 17. Father's Neme (First, Middle, Last) | | | | 18. Mother's Nerr | e (First, Middle | , Maiden Suman | ne) | |
| Y la Viant | Joseph Herbert | | | | Lillia | n C. Wa | rd | | 100 |
| Aard sand | 19a. Informant's Neme/Relationship (T) | rpe, Print) | 19b. Mailing | Address (Stree | et and Number or Flu | ral Route Numb | oer, City or Town, | State, Zip C | Code) |
| N = Bally | Judy Bowens | Niece | | | ake Place | , King | George, | Va. 2 | 2485 |
| AME altimore mit. Papes 1: populment of his populment of his populment of his populment it has refulery or other as | 20a. Method of Disposition 1\(\bar{\Delta} \) Burial 2 \(\bar{\Delta} \) Cremation 3 \(\bar{\Delta} \) 4 \(\bar{\Delta} \) Donation 5 \(\bar{\Delta} \) Other (Specify) | Removal from State | Plece of Disposition Completely, crema V | tory or other pla | January 20 Cemetery | Date 0,2000 | 20c. Location | | m. State Maryland |
| Balti permit. Departm importa any inju | 21. Signature of Funeral Service License | · // | Wi' | Vame and Addr 111ams | ess of Facility Funeral Ho | | Α. | | |
| | 230 Part Fotor the shares or count | let a title | | | horne Rd. | | | - | 0640 Approximete |
| Physician /Medical Examiner | 23a. Part1. Enter the officerie, or complete shock, or heart failure. List only or immediate Cause (Final disease or condition resulting in death) | ne cause en eact the | ita Gy | repli | alomity | | | 1 | Intervat Between Onset and Death |
| 2 4 5 | | Acut | for as a conseque | ence of): | Carle | | | Z | week |
| 60, be executed idean and burlei-transit | Sequentially list conditions, | | .00 | | | | | | |
| be en burde | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | (| 110- | | | | | | |
| 687 tifficets ag phys | | Due to | (or es e conseque | ence of): | | | | t | |
| BOX eth cert for use | | | | | | | | | |
| 1S, P.O. Box res that the death contribution by the estending to describe for use by Physician/N | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use cause given in Part I. | | | | | | | | the cause of death? |
| Cord requir | | | | | | 24a. Was | s an autopsy ormed? | com | re autopsy findings lable prior to spletion of cause eath? |
| II Relevante la | | | | | | 10 | Yes 2010 | | Yes 2 No |
| | 25. Was case referred to medical examiner? | | | | 26. Place of Dee | th (Check only | one) | 1 | |
| of Vita Physicien: this certific ral director. | 1 Yes 22 No | lospital: Depatient 2 | ☐ ER/Outpatient | 3 DOA | ther: 4 Nursing H | ome 5 Res | idence 8 🗆 Ott | ner (Specify) | |
| C 2 2 2 0 | 27. Manner of Death Thatural 5 Pending 2 Accident Investigation | 28a. Dete of Injury (Month, Day Year) | 28b. Time of Injury | M 28c. tnju | ary at ork?] Yes 2 □ No | 28d. Describe | how injury occur | red | 31177 |
| Division Complete to Attending Prothe Hospital or Attending Prothe Functed Director: After the completely filled in by the funeral Medical Certification: | 3 Suicide 6 Could not be determined | 28e. Place of Injury - At building, etc. (Special Control of the C | home, farm, stree cify) | t, factory, office | | | (Street and Numi | ber or Rural | Route Number, |
| DIVI To the Hospital or At Within 24 hours after of completely filled in by Medical Certiff | 29a. Certifier | ner: On the best of my kiner: On the basis of examinend manner stated. | | | | | | | |
| Toth Toth comp | 29b. Signature and title of certifier | 1 ,00 | | 29c. Licen | se number | | 29d. Date signe | | |
| | > Jally | tell | om 22c) (Trees | | 2975 | | 1-1 | 6-0 | 0 |
| | DANIEL M. HOWELL | | | | E 104 WAL | DORF, MD | 20603 | | |
| State | 31. Date filed (Month, Day, Year) | 32. Registrar's Sig | nature 4 | Lon | 1/1 | | | | |

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent'a Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month **Physician** Dora Kiwitt January 4, 2000 12:24AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Holy Cross Hospital Silver Spring Montgomery 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Dale of Birth (Month, Day, Year) Oct. 28, 1895 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1□M 2QF 135-20-2221 104 Poland Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 21 No Director Maryland notifie Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ris 23a or 4 Saddle Rock Court 20902 United States Funeral 14. Race - American Indian, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after 1 Yes 2 No 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 8 1 Yes 2 No Specify: Specify: À 3.☐.Widowed 4 ☐ Divorced White Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 10 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fit ment of Health and Mental H ant: if hem 27 is marked oth lary or other traumatic even Be Morris Alexanderoff Sarah Meklinsky 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marion Scambos/Daughter 604 N. Filmore St. Arlington, VA. 22201 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20e. Method of Disposition Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of important: If any injury or 01/06 King David Memorial Falls Church, VA. 4 Donation 22. Name and Address of Facility Stein Hebrew Funeral Home. 21. Signature of Fug 232 Carroll St. NW Washington, Ranke ant. Ento be disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, occ., and failure. List only one cause on each line. Approximate Interval Between Onset end Deeth **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Acute Respiratory arrest/Dysrhythmia Examine Due to (or as a consequence of): Examiner Atheroscolerotic Heart & Vessel Disease ician and burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) physician a Pneumonia Box 68760. Physician/Medicai Due to (or as a consequence of): USB 88 signed by the atte Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yes 2 No 3 Probably 4 Unknown Records, by 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy performed? completion of cause of death? page 2 has certificate 1 ☐ Yes 2 DONo 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: Be 25. Was case referred to medical axaminer? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2☐NER/Outpatient 3☐ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) Medical Certification: To 1 Yes 2 No this funeral 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After Matural 5 Pending after death. 1 Tyes 2 No investigation 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide rilled in 24 hours a Hospital *CxCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of autimination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) ination and/or investigation, in my opinion, death occurred at the time, date and place, and dua to the cause(s) To the To To the F 29b. Signeture and title of Varilles 29d. Date signed (Month, Day, Year) 29c. License number 00019924

State Registrar

31. Date filed (Month, Day, Year)
JAN 1 0 2000

30. Name and trodress of person who completed cause of death (Item 23a) (Type, Print)

Lawrence Oufiero, MD. 1500 Forest Glen Rd. Silver Spring, MD.20910 32. Registrar's Signature

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death # 5.Per Fam. PGC 1-13-00 cr 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death Physician Month Yaar Harold M. Kielty 8, 2000 January 9:00PM /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Clinton 6300 Woodley Road If Under 24 Hrs. 5. Social Security Number 9799 8. Date of Birth (Month Day Year) Dec. 7, 1916 If Under 1 Year 7. Age (In yrs. last birthday) 9. Birthplaca (State or Foreign **Funeral** Days Months Hours 10 M 20 F Alberta, Canada 476-12-0799 83 Yrs. Director Usual Rasidence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas 2 No Directo Clinton 28a-t Maryland | Prince George's 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? b 6300 Woodley Road Nerna 23a USA Funeral 20735 12. Was Decedent Ever in U,S. Apped Forces? VAYes 2 □ No WWII IYas, Give Year or Dates: Korea 14. Raca - American Indian, 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, spacify Cuban, Mexicen, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: 8 Specify: White à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiere. Elementery/Secondary (0-12) College (1-4or 5+) US Navy Cryptographer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be nearl of Health and Mental I net: If hern 27 is marked of Margaret Webb Thomas F. Kielty 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) viant: If ham 27 is a viury or of Joy B. Kielty/Wife Same as item 10 20b. Place of Disposition (Name of cematery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State MBuriai 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arlington National Cem. 1/20/2000 Arlington, VA. 21. Signature of Funaral Sarvice Licensee George P. Ralas Funeral home, P.A. 6160 Oxon Hill Rd. Oxon Hill, Md. 20745 lions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Approximeta Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final Metastatic Colon Cancer to Liver disease or condition resulting in death) Examine Examiner physician and the burial-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of): USB Part II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? hronic Obstructive Lung Viscase 1 Yas 2 No 3 Probably 4 Unknown Completed by 24b. Wera autopsy findings available prior to completion of causa of death? onic Pulmonary Aspergillosis 24a. Was an autopsy parformed? iabetes Non weulin dependent 1 Yes 2 No 25. Was case referred to medical axaminer? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 20 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Dete of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending 1 Natural 1 Yes 2 No death. invastigation 2 Accident 24 hours after deat Funeral Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide filled in 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated.
2 Medical Examiner: On the basis of examination and/or investigation. In my pointon, death occurred at the time, date and place, and due to the 29a. Cartifier niner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only

To the Hosp within 24 hor To the Fune completely fi

DHMH 16 Rav 6/95

The law requires that the death certificate be executed

P.O. Box 68760.

Records.

Division of Vital

or Attending Physician:

Hospital

the Marvier

filed within 72 hours after

Baltimore, Maryland 21215-0020

Registrar

31. Date filed (Month, Day, Year) JAN 1 1 2000

one) 29b. Signature and

> od cause of death (Item 23a) (Type, Print) James Henderson, II, M.D.
>
> ML 1050 W. Pen'McTer Rd Awdrews AFB MD 9 MOOS/SGOML 32. Registrar's Signature

()0055528

29d. Date signed (Month, Dev. Year)

January

The same is the same of the sa

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 11 12305

| | | | | | | Certificate of | Death | | Reg. No. | 0 (| 02.000 | |
|------------|--|------------------|---|---|---|---|----------------------|---------------------|---------------------|--------------------------|---|--|
| Г | | | 1. Decedent's Nama (First, Middla, | .ast) | | | | 2. Date of De | ath | Vene | 3. Time of Death | |
| | Physic /Medi | | SHEILA 3 | OB KIEF | EEI | 2 | | O I | 07 2 | Yaar | 7:49 pm | |
| | Exami | | 4a. Facility Name (If not institution, | ive street and number) | | | 4b. City, Town, or t | | | | | |
| 1 | | | 2013 Hon | IEWOOD ! | 204 | D | ANNA | POLIS | ANN | EA | PUNDEL | |
| | Funeral Director | | | Sax 7. Age (In yr 1□ M 2以 F 73 | | nday) If Under 1 Year Months Days | | (Month, De | by, Year) - 1926 | 9. Birthp Cour Aus | olace (Stete or Foreign otry) stralia | |
| | and ** | | 10a. Stata 10b. County | 10c. (| City, Town | or Location | | | | 1 | 0d. Inside City Limits | |
| | f ehe | 0 | MD. Anne A | run do 1 | Anna | alia | | | | | 1 ☐ Yes 2 🛣No | |
| | the 288 | 20 | 10e. Street and Number | I dilde I | Allila | 10f. Zip Code | | | 10g. Citizan of W | /hat Cour | ntry? | |
| | with w | Funeral Director | 2013 Homewood Road 21402 | | | | | | | | | |
| | 99th | era | 11. Marital Status | 12. Was Decedent Ever in | IIS | | | nacify Yas or No | | JSA - Americ | can Indian, | |
| | Hen Hen | 5 | 1 Never Married 2 Married | Armed Forcas? | 0,0. | Was Decedent of If Yes, specify Cut | pan, Mexican, Puert | o Rican, etc.) | Blac | k, White, | | |
| 5-0020 | ges 1 and 2 should be filed within 72 hours after deeth with the Maryland it of Health and Mental Hygiene. If Item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examinations to collect | by | 3 Widowed 4 □ Divorced | If Yes, Give | | 1 ☐ Yes 2 No | Specify: | | Specify. | White | | |
| 0 | 2 hou | | 15. Decedent's | Education | 16a. | Decedent's Usual Occu | petion | | 16b. Kind of Bu | | | |
| 215 | nin 7 | Completed | (Specify only highest grade complated) (Give kind of life. DO NO | | Give kind of work done life. DO NOT use retin | kind of work done during most of working DO NOT use retired) | | | | , | | |
| 2121 | filed within Hygiene. ither than | Eo | Elementary/Secondary (0-12) | College (1-4or 5+) 5 + | | Tennis Instructor | | Scho | | 01 | | |
| P | ent, | BeC | 17. Father's Name (First, Middle, La | st) | . ' | | T | ne (First, Middle | , Meiden Sumem | е) | | |
| Maryland | 2 should be and Mental ie marked o | ToE | B. Cedric Job | | | | Esther | Cambrid | ge | | | |
| any | should ind Men marke umatic | | 19e. Informent's Name/Relationship | (Type, Print) | 19b. | Mailing Address (Stree | | | 0 | Stete, Zip | Code) | |
| | 1 and 2 Health a am 27 is | | Thomas J. Kiefe | r / Son | P | O. Box 508 | Sparks | MD. | 21152 | | | |
| e, | f Her frem othe | | 20a. Method of Disposition | 20b | Placa of | Disposition (Name of cremetory or other plant | - T | Date | 20c. Location - | City or To | wn, Stata | |
| E | Pages nent of h int: If he | | 1 Burial 2 Cremation 3 4 Donation 5 Other (Spe | □Ramoval from State | | litan Crem | 1 | 14-00 | Alexand | ria | T/A | |
| altimore, | permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other th | | 21. Signatura of Funeral Service Lic | | cropo | | 2 | | | | | |
| B | permit. Departn Importa any Inju | | P. Bush | Powell | | 147 Duke o | f Glouces | n M. la ster St, | ylor fur Annapol | ierai .is, | Home, Inc. MD 21401 | |
| | | | 23a. Part1. Enter the disease, or co shock, or heart feilure. List on | mplications that caused the de y ona cause on each line. | ath. Do n | ot enter the mode of dy | Ing, such as cardiac | or respiratory a | rrest, | | Approximate Interval Between | |
| | Physician | | | | | | | | | | Onset and Death | |
| 1 | /Medical Examiner | | Immediate Ceuse (Final disaasa or condition | METAS" | TAT | IC BR | BAST | CANC | GIL | i | OZYEARS | |
| н | LAGIIIII | _ | resulting in death) | Due to | (or as a c | onsequence of): | | | | [| | |
| _ | ed sit | -ine | | BREAS | STC | HUCER | | | | | 5 Yz YEAM | |
| 60, | icete be executed physician end s the bunal-transit | al Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury | Due to | (or as e co | onsequence of): | | | | | | |
| Box 68760, | £ 00 | n/Medical | that initiated events resulting in death) Last | Due to | (or es a co | ensequence of): | | | | | | |
| m | death ce | Physician/ | Part II. Other significant conditions | contributing to death but not r | a audima la | the underlying course of | han in Dant I | 20h Did | tohanna una nam | dellareta de | the same of double? | |
| 0 | by the detected | hys | ratti. Other significant conditions | contributing to death but not re | asuning in | the underlying cause g | van in Parti. | | 1 | | the cause of death? | |
| 9 | \$ 8 g | by P | | | | | | 1 🗆 | 108 2/200 | 3 Proi | bably 4 Unknown | |
| Records, | The law requires ate hes been sign page 2 should be | | | | | | | 24a. Was | an autopsy | 24b, W | ere autopsy findings | |
| 00 | v require been si should | Completed | | | | | | perfo | ormed? | CO | ailable prior to mplation of cause | |
| Re | The lav ate hes page 2 | ם | | | | | | | ~ ~ | | death? | |
| m | | | 05.14 | | | | | 10 | Yes 200No | 1 [| JYes 2□ No | |
| of Vital | Physician: this certific ral director, | o Be | 25. Wes case referred to medical examiner? | Hospital: | | _ 0 | 28. Place of Dee | 1/ | | | | |
| of | Phys this ral di | - | 1 ☐ Yes 2 ☐ No 27. Menner of Death | 1 □ Inpatient 2 | ☐ ER/Out | Datient SLI DOA | 4 Industrig In | | dence 8 Other | | N) | |
| On | ding I h. After funer | tlon | Natural 5 Pending | 28e. Dete of Injury (Month, Dey Year) | in | ury Wo | ork?]Yes 2□No | EUG. DESCRIDO | now injury occurr | 50 | | |
| Division | or Attending efter deeth. Director: After d in by the fune | Certification: | 3 Sulcide 6 Could not | be | home fan | | | 28f Location (| Street and Number | er or Rura | al Route Number | |
| ō. | 한 등 등 등 | ert | 4 Homicide determine | building, etc. (Spec | cify) | ii, street, ractory, omca | | City or To | | or riara | , riodio ridilibor, | |
| | Hospital 24 hours Funeral stely filled | - 1 | 29e. Certifier Certifying F | hyalclan: To the best of my kr | nowledge | death occurred at the t | ime date and place | and due to the | cause(e) and may | nnor ec el | totod | |
| | To the Hospital or within 24 hours effe To the Funeral Dir completely filled in | edical | (Check only 2 Medical Expone) | miner: On the basis of exemir and menner stated. | netion and | or Investigation, in my | opinion, death occur | rred at the time, | dete end place, a | ind due to | the cause(s) | |
| | ithin o the ompl | Me | 29b. Signature and title of certifier | A B A | | 29c. Lican | sa number | | 29d. Date signed | (Month, | Day, Year) | |
| | F ≯ F 0 | | · API I | 10/11/10 | 0 | na | 39774 | | 011 | 10 | 100 | |
| | | | NU | | | | | | 01/ | 1 | | |
| | | | 30. Name and address of person wh | completed cause of death (IIII | om 23a) (T | oby CE | NIER | CAR | STON | 10 0 | WOLFF, NO | |
| | Sta Registr | - | 31. Date filed (Month, Day, Year) JAN 1 3 20 | 32. Registrar's Sign | nature | 1. Sport | W | | | | | |
| | | | | | | | | | | | | |

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Cértificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month 10, 2000 4:11 P.M. Mary Ann Krissillas January 4e. Fecility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth 1615 Trumbulls Court Crofton Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 8. Dete of Birth (Month, Dey, Year) 1□ M 20 F Deys 85 Yrs 220-38-2962 Oct. 19,1914 Washington, D.C 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Anne Arundel Crofton 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 1615 Trumbulls Court 21114 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give A Yeer or Detes: 11 Marital Status Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: 3 Wildowed 4 □ Divorcad White Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12th Homemaker Home 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Frank D'Angelo Maria Garsalo 19e. Informent's Neme/Relationship (Type, Pnht) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Donna Krissillas/ Daughter 1615 Trumbulls Court Crofton, MD 21114 20b. Plece of Disposition (Neme of cametery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burlei 2 X Cremetion 3 ☐ Removel from State 1-11-00 Alexandria, Virginia 4 ☐ Donetion 5 ☐ Other (Specify) Metropolitan Crematory George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Părt1. Enter the diseese, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or hear feilure. List only one cause on each line. Approximate Intervel Between Onset end Deeth Immediete Ceuse (Finel disease or condition resulting in deeth) HEVKEMIA Due to (or es e consequence of): LympHomB Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es a consequença of): Due to (or es a consequenca of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributs to the cause of death? ALLINON APPAR OF Probable ACTION

Physician /Medical **Examiner**

Bud

Physician

/Medical

Examiner

Director

Funerai

Be Completed by

Funeral

Director

Dermit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of health and Mantai hygiene.
Important: if item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Exercises.

the buriel-trai To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completaly filled in by the funeral director, I

The law requires that the death cartificate be executed

Division of Vital Records, P.O. Box 68760,

Physician/Medical ۵ Completed Be Certification: To

| 2 | | | | | | _ '' | 148 22340 | S FIODEDIY 4 ONKHOW |
|---|--------------------------|--|--|-----------|---|--|---------------------------------|---|
| Completed | | | | | | per | s en eutopsy formed? | 24b. Were autopsy lindings available prior to completion of cause of death? 1 Yes 2 No |
| 25. Wes case referred to me exeminer? | | | | | 28. Pieca o | Deeth (Check only | one) | |
| O 1 Yes 2 No | н | lospital: 1 🗆 Inpatient 2 🗀 | ER/Outpatient | 3 DO | A Other: 4 Nurs | Ing Home 5/2 Res | sidence 6 🗆 Oth | er (Specify) |
| 27. Menner of Deeth | ending vestigetion | 28e. Dete of Injury (Month, Dey Year) | 28b. Time of Injury | M 2 | Bc. Injury et Work? 1 Tyes 2 No | - FORTH 17- | how Injury occur | red |
| 4 ☐ Homicide d | ould not be etermined | 28e. Plece of Injury - At h building, etc. (Speci | ome, ferm, street, | , fectory | , office | 28f. Location City or To | (Street end Numb own, Stete) | per or Rural Route Number, |
| 29e. Certifier AN Car (Check only one) | tifying Phys | Ilclan: To the best of my knoter: On the bests of examine and menner steted. | owledge, deeth oc ation and/or invest | curred e | ot the time, dete end p In my opinion, deeth | plece, end due to the occurred et the time | e ceuse(s) and mo | anner es stated. and due to the cause(s) |
| 29b. Signature and tille of or | ertiflige | 101 | | 29c. | License number | | 29d. Date signe | d (Month, Day, Year) |

of person who completed cause of deeth (Item 23e) (Type, Print) Stanley Watkins, M.D. 900 Bestgate Rd. Annapolis, Maryland 21401

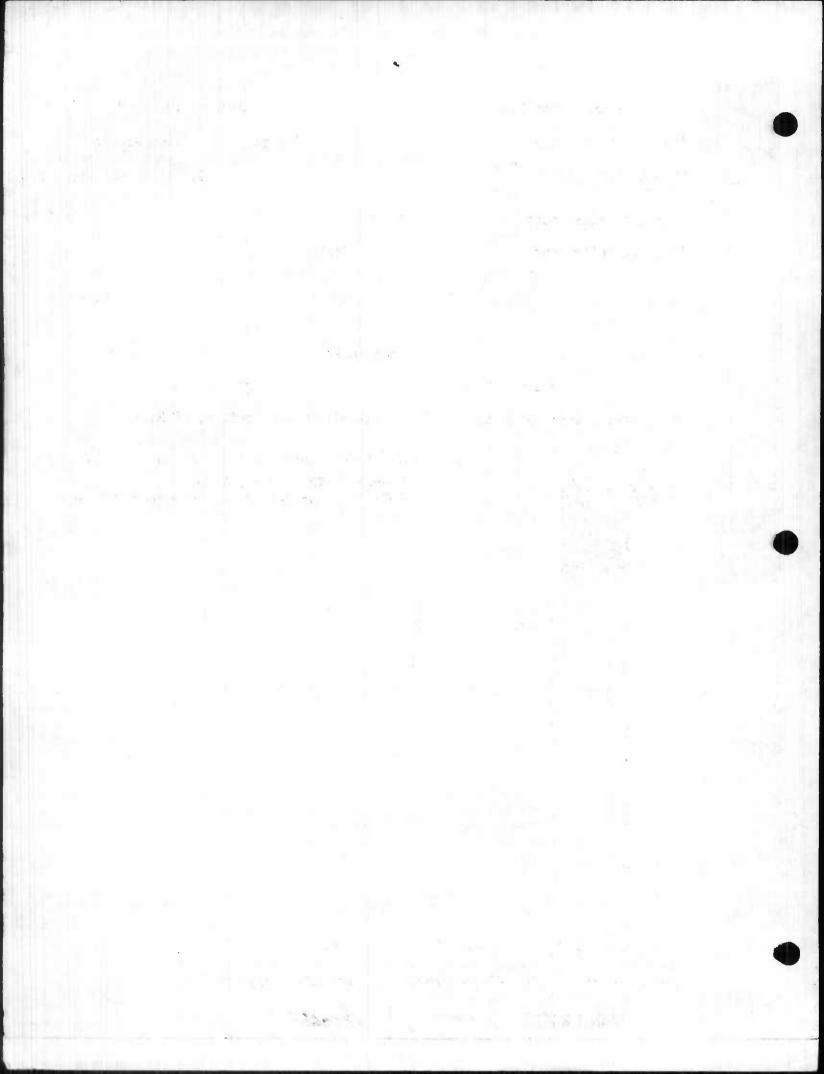
State Registrar

31. Dete filed (Month, Day, Year)



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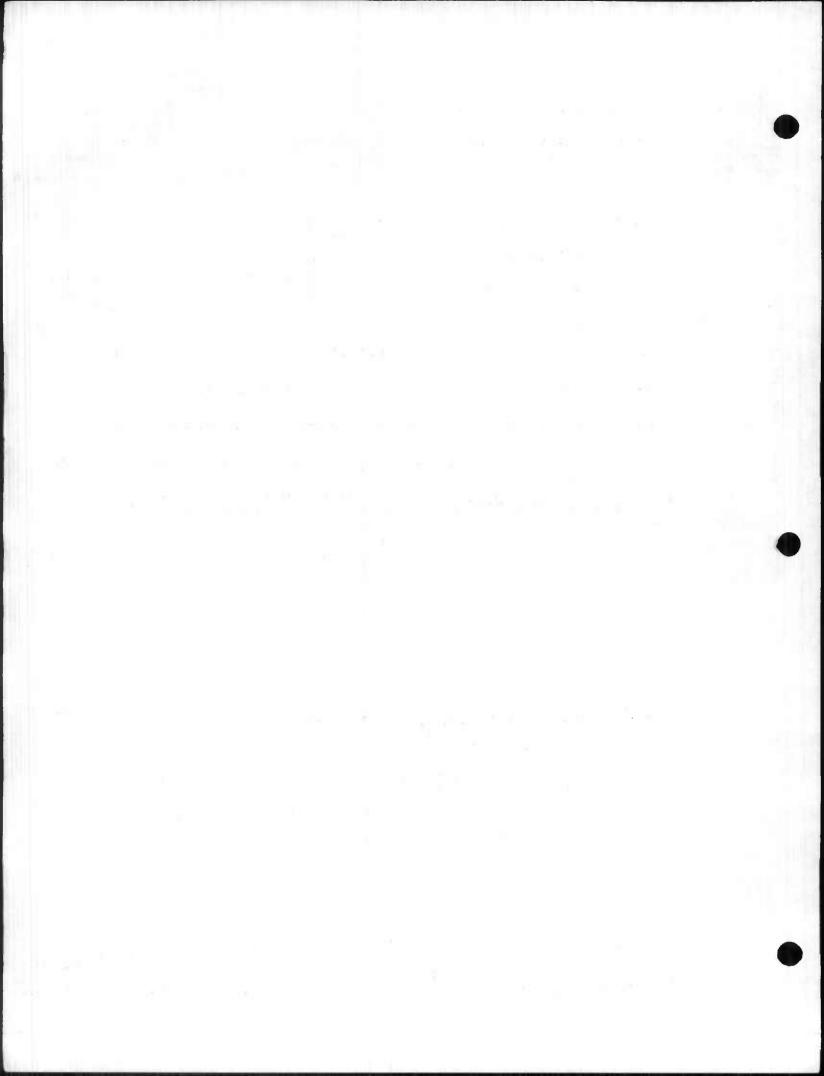
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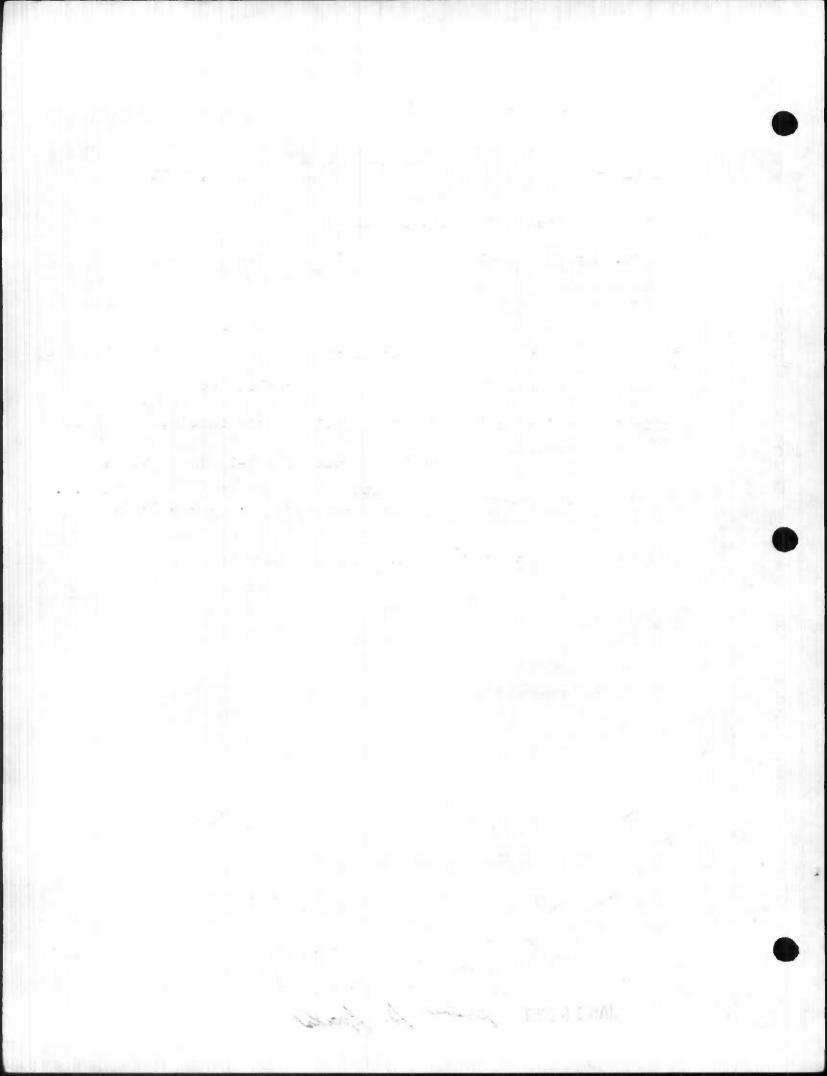
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Emma Minerva LaFreniere Jan. 14, 2000 12:30 am /Medical 4a. Facility Nama (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Caroline Nursing Home, Inc. Denton Caroline If Undar 1 Yaar If Under 24 Hrs. Hours Min, 5. Social Security Number 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dey, Year) Birthplaca (Steta or Foreign Country) **Funeral** 1□M 2\ F Months Days Director 187-18-4854 78 Aug. 28, 1921 Pennsylvania Usuai Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show chotified at 1 Yes 2 No Director Maryland Dorchester Cambridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? than "natural", or items 23s or the Medical Examiner must be r Apt. 904, 216 Meteor Ave. 21613 U.S.A. Funeral 12. Was Decedent Ever In U.S. Armed Forces? Was Decedant of Hispanic Origin? (Specify Yes or No-lf Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Yaar or Datas: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: þ Specify. 3 N Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest greda completed) 16b. Kind of Business/Industry filled within Hygiene. College (1-4or 5+) Elementery/Secondary (0-12) Housewife Own Home 17. Father's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Peges 1 and 2 should be nent of Heelth and Mental Allyson Bender Anna Hartman 19a. Informant's Name/Relationship (Type, Print) Daughter 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Depertment of Heelth are important: If item 27 is any injury or other trans Frances E. LaFreniere 8588 Dogwood Blossom Lane, Denton, MD 21629 20b. Place of Disposition (Neme of cematery, cremetory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cambridge Crematory 1-14 Cambridge, MD 21. Signature of Funeral ServicesLicensee 22. Name and Address of Facility Curran-Bromwell Funeral Home, P.A. 308 High St., Cambridge, MD 21613

Application of the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, Applications. Approximate Interval Between Onset end Death **Physician** /Medical Immediate Cause (Final disease or condition resulting In deeth) Examiner Examiner The law requires that the death certificate be executed the bunal-transit Sequentially list conditions, if any, leeding to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical Due to (or as a consequence of): signed by the ettending p Part II. Other significant conditions contributing to death but not resulting in the underlying sease given in Part I. P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, Be Completed by 24e. Wes en autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? page 2 2 No 1 Yas 2 No certificate of Vital Hospital or Attending Physician: 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Hospitat: 1 ☐ Inpetient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Dey Year) illed in by the funeral 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After Division 5 Pending investigation Natural 1 Tes death 2 Accident after death 3 Suicida 6 Could not be determined 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide a Funeral 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and placa, and due to the ceuse(s) and manner as stated. Medicai 29a. Certifier Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and mannar stated. within 2 To the 29b. Signature and title of cartifian 29c. Licansa number 29d. Data signed (Month, Day, Year) 21629 30. Nama and address of person who completed cause of deeth (Item 23e) (Type, Print) Samos 31. Data filed (Month, Dey, Yeer) 32. Registrar's Signature State JAN 19 2000 Registrar

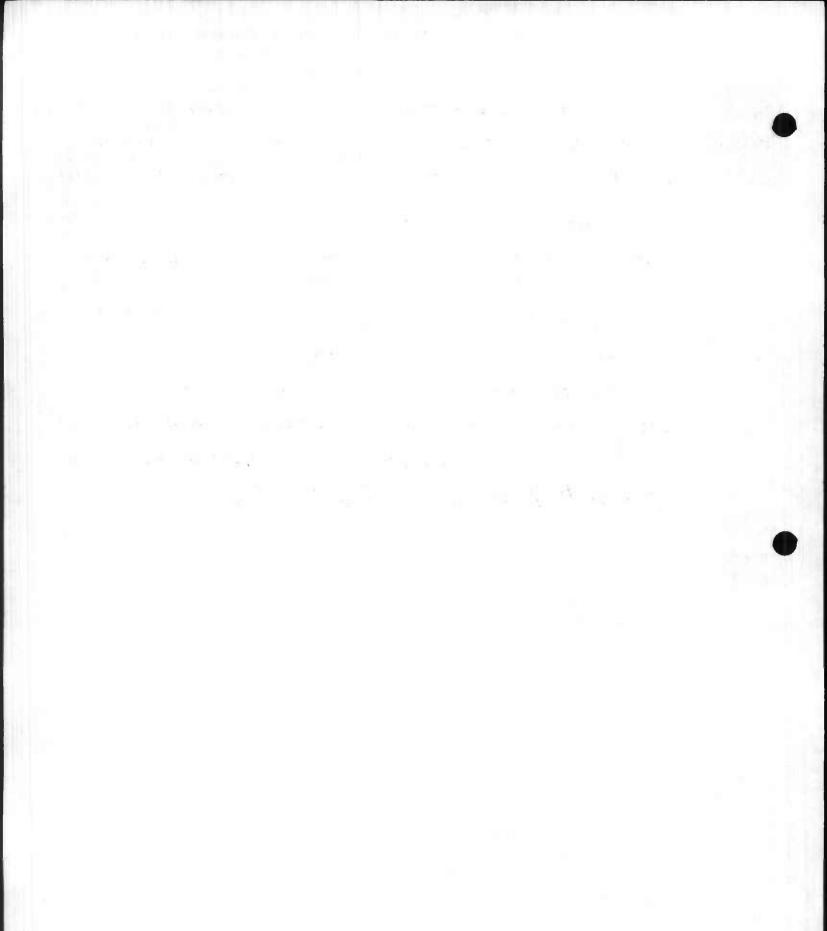


| The possible of the possible o | Part | | | | | Ce | ertificate d | or Death | 7 | R | ng. No. | | |
|--|--|--|---|---|--|--|---|---|--|--|---|---|--|
| The process of the pr | ## AC CALLY CONTROLL CONTROLL AND ACT | | | | | | 5.1.78 | | 2. | | | Veer | 3. Tima of Dea |
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| Text | Same | rs. last birthday) | | | | | | | | Date of Birth | | 9. Birthol | ace (State or For |
| The stream of Number 2 (10 Country) and Carroll Westminster Westmi | Description | Vec | 2[]xF | 2CKF | ₹ 00 | Yrs. | Months Da | ys Hours | - Andrew | | | | |
| Separation Sep | 15. Decedent's Education 15. Decedent's Education 15. Decedent's Education 15. Decedent's Education 16. Decedent's Usual Course during most of working (First, Middle, Last) 16. Not use reliancy 16. Decedent's Usual Course during most of working (First, Middle, Last) 18. Mother's Name (First, Middle, Malicion Surname) 18. Nother's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malicion Surname) 18. Nother's Name (First, Middle, Malicion Surname) 18. Nother' | 0 | 00 | | 00 | | 1 | | 18 0 | V I | 1911 | LEHR. | Land |
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| 20.5 St. Merk No. Y 218 11. Marial Salaus 12. Secretary 13. Marial Marial Salaus 14. Marial Salaus 15. | 11 Martia Status | ** | 7 | 2 | | 7 | | | | | | | 1 ☐ Yas 2 ☐ |
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| The composition of the process of the control of the composition of | Security Specify Spe | r in U,S. 13. We | Vas Decedent Ever in Armed Forces? | Was Decedent Armed Forces? | Decedent Ever in d Forces? | n U,S. 13. | Wes Decedent If Yas, specify (| of Hispanic Or Cuban, Mexica | rigin? (Specifi in. Puerto Ric | y Yes or No- an, etc.) | | | |
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| Sidney Thomas Borer 18. Monter's Name (Prest, Models, Massion Summan) 18. Massion Name (Prest, Massion Name (Prest, Massion Name (Prest, | Sidney Thomas Borer 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zp Code) | | ear or Datas: | rear or Datas: | or Datas: | | 10100 2/2 | то ороспу | | | Эрвск | Whi. | te |
| Sidney Thomas Borer 18th Mores Name (Prest, Morde, Mastern Stame) 18th Mores Name (Prest, Morde, Name (Prest, Name | Sidney Thomas Borer | 16a. Deceder | n . | n | 4 | 16a. Dece | edent's Usual Oc | cupation | es of wordsing | | 16b. Kind of E | Business/Ind | ustry |
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| Scidney Thomas Borer 19s. Informant's Name/Paladionning (Type, Pirt) Philip Lawyer (Nephew) 30s. Method of Deposition 1 Dentist 2 (Decreation 3 (Percention 3 (Percenti | Sidney Thomas Borer 19s. Informant's Name-Relationship (Type, Print) Philip Lawyer (Nephew) 8 Marbeth Hill Westminster, MD 2115 20s. Method of Disposition 10 Birds 2 QCceretion 3 Bernoval from Stata 4 Donation 3 Dother (Specify) 21. Signature of Funeral Service Leansee 22. Symature of Funeral Service Leansee 23. Perf. Enter the disease, or complications that Caused the death. Do not enter the mode of dying, such as cerdac or respiratory entering in death) 22. Approx. App | , 500 | | | | | | - | er's Nama (F | | | | |
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| | anylar d at | _ | 10a. Stete 10b. County | | 10c. Ci | ly, Town or | | | | | | | 1 | 0d. Inside City Limits | | | | |
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| | £ 0 g | | 10e. Street and Number 502 North Sixth S | troot | | | | p Code 21629 | | | | 10g. Citizen of | | | | | | |
| | eath 23 | Funeral | 11. Meritel Stetus | | edent Ever in U | S 13 | | | ispanic Origir | n? (Snecifi | Ves or No | United | State ce - Americ | | | | | |
| 0 | 72 hours after death with the Maryland natural; or items 23s or 28s-f show deal Examiner must be notified at | Fun | 1 Never Merried 2 Merried | Armed Fo | orces? 2₺ No | | it Yes, spe | ocity Cube | n, Mexican, I | Puerto Ric | an, etc.) | | ck, White, | | | | | |
| 02 | ours a | by | 3 💢 Vidowed 4 □ Divorced | If Yes, Gir Yeer or D | Ve ev | | 1 □ Yes | 2)(2) No | Specify: | | | Specifi | _{y:} casia | n | | | | |
| 21215-0020 | hin 72 hours af 3. In *natural", or Modical Exam | Completed | 15. Decedent's Edu (Specify only highest grad | cation le completed) | | (Gh | edent's Usu | ork done | durina most a | of working | | 16b. Kind of B | usiness/In | dustry | | | | |
| 121 | | du | Elementery/Secondary (0-12) | College (| 1-4or 5+) | | DO NOT | | | | | | | | | | | |
| | H H H | ပိ | 11 HS Grad 17. Fether's Neme (First, Middle, Last) | | | Owne | er/Ope | eraco | | s Nama (F | irst Middle | Meiden Sumer | nel | | | | | |
| Maryland | S E S | To Be | Norman Lacy | Steve | ns | | | | | | | erta Pa | | | | | | |
| ary | d 2 should th and Mer 7 is marke traumatic | - | 19a. Intorment's Neme/Reletionship (T) | | | 19b. Me | iling Addres | s (Street | | | | | | Code) 21632 | | | | |
| | Transport | | T. Alan Lockerman | | Son | 278 | 91 Li | den S | choo1 | Road | , Fed | eralsbu: | rg, M | aryland | | | | |
| ore | of Healt of Healt I Item 2 r other | | 20e. Method of Disposition 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ F | | | Pieca of Disponentery, or | position (Ne emetory or | me of other plea | e) | | Dete | 20c. Location | - City or To | wn, Stete | | | | |
| E | ment of land: If its lary or o | 0 3 | 4 Donetion 5 Other (Specify) | | | nton Cemetery | | | 1/2 | 20/200 | 000 Denton, Mary | | aryland | | | | | |
| Baltimore, | permit. Peges Department of I Important: If its any injury or or | | 21. Signature of Funeral Service Licens | 7/2 | | | 22. Name e Moore | nd Addre | ss of Fecility eral H | lome, | P.A. | | | | | | | |
| | 00260 | | Jandofint. | 11100 | ve_ | | 12 So | uth | Second | Stre | et, I | enton, | MD 2: | 1629 | | | | |
| | Physician /Medical Examiner | 34 | 23a. Part1. Enter the diamen, or compishook, or heart tailure. List only of immediate Cause (Final disease or condition resulting in deeth) | | Due to (c | 2 | Ces | 210 | on | 08- | th | | 1 | Approximate Interval Between Onset and Death | | | | |
| | nsit | nine | | b. 50 | rac | | | | 1 5. | 6 82 | 212 | to ti | c - | 0 | | | | |
| ć. | execu in and iel-tra | Examiner | Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury | | Due to (d | or as e cons | equence of) | : | | | | | i | | | | | |
| 8760, | death certificate be executed e attending physician and of for use as the buriel-transit | dicai | Ceuse (Diseese or injury thet initieted events resulting in deeth) Last | c | Due to (c | r as e conse | equenca of) | • | | | | | | | | | | |
| 9 | ing pt | Med | resulting in deetily cast | | | | | | | | | | - | | | | | |
| Box | eath certific attending p | Physician/Me | | 0 | | | | | | | | | | | | | | |
| 0 | 2 5 5 | ysic | Pert li. Other significant conditions con | ntributing to de | eath but not res | ulting in the | underlying | cause giv | en in Pert I. | | 23b. Did | obacco uae co | entribute to | the cause of death? | | | | |
| 0_ | | | Renal a | سعم | ff1c. | ene | ~ | | | | 10 | Yea 25No | 3 Pro | bably 4 Unknown | | | | |
| rds, | een sign hould be | ed by | Di-bates | | | | 1 | | | | 24e. Wes | en autopsy | 24b. W | era autopsy findings | | | | |
| Record | - 9 8 | Completed | 01-00-162 | | | | | | | _ | perio | med? | CO | ellable prior to mpletion of cause death? | | | | |
| | 0 - 2 | EO. | | | | | | | | | | | Yas 25 No | | | | | |
| Vital | | Be | 25. Wes case reterred to medical examiner? | | | | | | 26. Place o | of Death (C | heck only o | ne) | 1 | | | | | |
| of | Physician: this certific ral director, | 70 | 1 ☐ Yes > ≥No | | | ER/Outpati | | | - Carred 15 | | | dence 6 □Oth | | y) | | | | |
| | Affer funer | lon: | 27. Menner of Deeth 1 ☐ Maturel 5 ☐ Pending | 28a, Dete (Mon | of Injury th, Dey Year) | 28b. Time Injury | | 28c. injun Wor | | | . Describe | now injury occur | rred | | | | | |
| Division | Attending ir death. ector: Afte by the fune | Certification: | Icat | Icat | Icat | Icat | 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be | 28e Piece | of thinny - At h | ome fem s | M street fector | 1 Yes 2 No | | | Location (Street end Number or Rural Route Number, | | | I Route Number |
| ρίς | or Attend after death Director: / d in by the i | ertii | 4 Homicide determined 28e. Pieca of Injury - At home, ferm, street, fectory, of building, etc. (Specify) | | | | | | | | City or To | | 001 01 11016 | in rioute reamber, | | | | |
| | To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune | edical C | | | | 29e. Certifier (Check only one) 1 Certifying Physical Examination (Check only one) | ner: On the bi | | | | | | | | | | | |
| | o the | Mec | 29b. Signeture end title of certifier | ono men | noi stoteu. | | 29 | 29c. License number 29d. Dete signed (Month, Dey, Yes | | | | | Dey, Year) | | | | | |
| | - s - o | | MANTE | | an | | 7 | 000 | 530 | 35 | | 1/19 | 120 | 000 | | | | |
| | | | 30 Name and address of person who or | projeted caus | e of death (Iter | n 23a) (Type | Print) | I POP 1 | D Ead | lora 1 - | hares | MD 216 | | | | | | |
| | | | 30. Nama and address of person who of Melinda Butler, N | | | | A A | Vellu | e, red | Grais | spata. | 2m 515 | 346 | 32 | | | | |
| | Sta Registr | te | 31. Dete tiled (Month, Day, Year) | | legistrer's Signe | | | , | | | | | | | | | | |



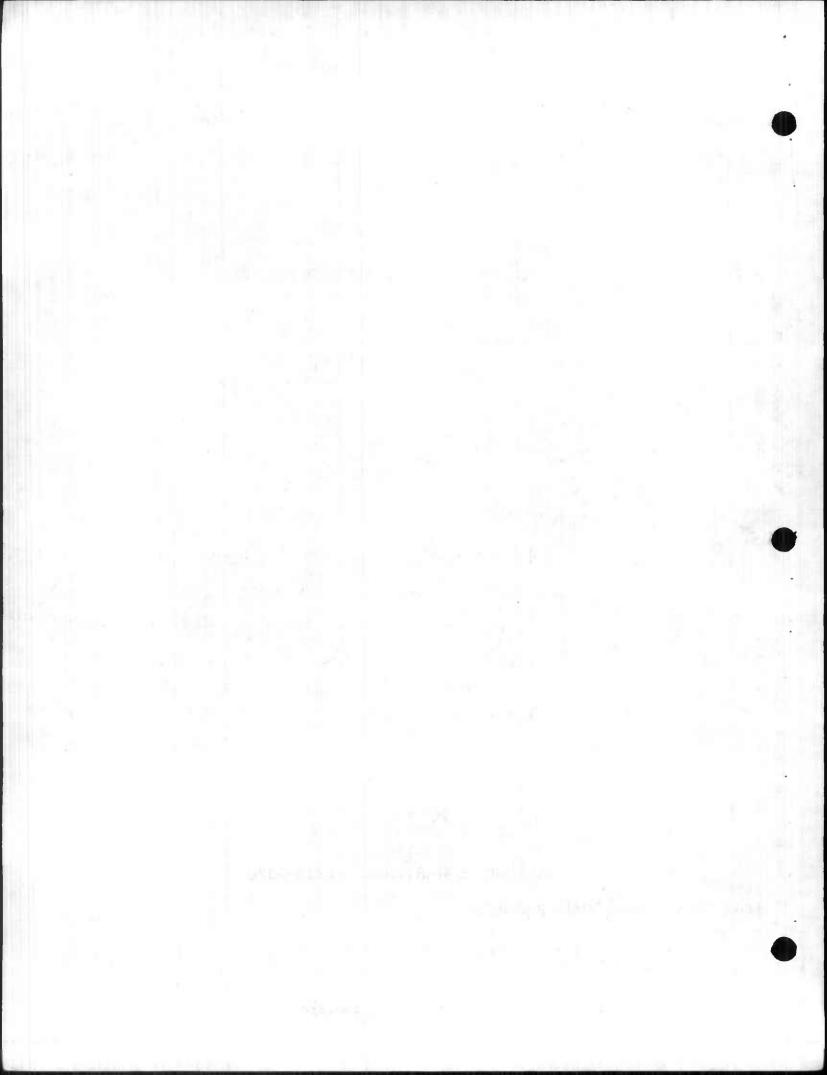
Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Month **Physician** Ethel Beatrice Lundquist January 17 2000 8:56pm /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Civista Medical Center LaPlata Charles 5. Social Security Number If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) 8. Dete of Birth (Month, Day, Year) **Funeral** Hours 1□ M 252 F Months Days Min Yrs. Director 147-07-4538 3-14-1921 PA 10e State 10h County 10c. City. Town or Location 10d. Inside City Limits ortant: if item 27 is marked other than "natural", or item 23a or 28a-f show Injury or other traumatic event, the Medical Examinal must be notified at MD 1 ☐ Yas 2 ☐ No Charles Port Tobacco Director the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7635 Carley Drive 20677 USA deeth Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ②CD00 If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yas or No If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14 Bace - American Indian 11 Marital Status permit. Pagas 1 and 2 should be filed within 72 hours after of Department of Health and Mentel Hygiena. Important: if them 27 is marked other than "natural", or heary injury or other trauman. Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-6020 1 Yes 2 No Specify: white Specify: p 3√2 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Telephone Co. Telephone Operator 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 8 Robert Brown, Sr. Stella Evans 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7635 Carley Dr., Arthur Lundquist Port Tobacco, MD 20677 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stete 1 ☑ Surial 2 ☐ Cremation 3 ☑ Removal from Stata +22-2000 4 Donation 5 Other (Specify) Center Union Cemetery East Earl, PA 17519 21. Signature of Eumerel Service Licenses 22. Nama and Addrass of Facility Eckenroth Home for Funerals 209 E. Main St., Terre Hill PA 17581 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart feilure. List only one cause on each line. Approximata Interval Batween Onsat and Deeth **Physician** Xone /Medical Immediate Cause (Finel disease or condition resulting in death) Hor Examiner Examine physician and the burial-transit The law requires that the death certificate be asscuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated assorts. Box 68760. Physician/Medical that initiated events resulting in death) Last 997 0 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. 23b. Did tobacco use contribute to the cause of death? signed by t Unknown 1 Yes 2 No 3 Probably ò 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed has 1 ☐ Yes 2 ☐ No 1 Yes Division of Vital 25. Was case referred to medical examiner? 8 26. Place of Deeth (Check only one) 1 ☐ Yes 272 No Other: 4 Nursing Homa 5 Residence 8 Other (Specify) 2 1 Inpatient 2 DER/Outpatient 3□ DOA this n 24 hours after death.

Ne Funeral Director: After th
pletsly filled in by the funeral 28a. Data of Injury (Month, Day Year) Certification: 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural or Attending 5 Pending investigation 1 Yas 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital o within 24 hours at To the Funeral D 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and dua to the cause(s) and menner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the edical pletely (Check only one) iner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and magnetistated. 29b. Signature and title of certifie 29c. License number 29d. Data signed (Month, Day, Year) D-20629 11345 Pembrooke Square and access of person who completed causa of death (Item 23a) (Type, Print) George H. Wathen, MD Suite 103, Waldorf, Maryland 20603 31. Data filed (Month, Day, Year) 32. Registrar's Signatura State 2000 JAN31 Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygier 0 23 | Certificate of Death

| | | | Ce | rtificate | of Death | | Reg. No. | | | |
|--|--|---|----------------------------------|-------------------|----------------------|--|---------------------------|-------------------|---|--|
| | 1. Decedent's Nama (First, Middla, L. | ast) | | | | 2. Data | | Vees | 3. Tima of Death | |
| Physician | Joseph | Lewis | | | Mace | / Jan | | Year | 11 16 0- | |
| /Medical Examiner | 4a Facility Nama (If not institution, gi | ve street and number) | | | | vn, or Location of | | nty of Death | | |
| LAMINITE | Tolone 1 | topking Hospital | | | Balle | Love City | Ra | Hims | 02 | |
| Franci | | | s. last birthday | If Under 1 | | | of Birth h, Day, Year) | 9 Birth | place (State or Fore | |
| Funeral Director | | IDM 2DE | 4.1 Yrs. | Months I | Days Hours | Min. (Mont | 3, 195 | 8 Cou | place (Stata or Fore ntry) FL | |
| Pu & | 10s. Stata 10b. County | 10c, (| City, Town or L | ocation | | | | | 10d. Inside City Lim | |
| r 28a-f show | | | | | | | | | 1 ☐ Yas 2 ☐ I | |
| oct of s | | egany | Cu | mberl | | | 1 | | Λ | |
| ifer death with the Maryland r flerm 23a or 28a-f show riner must be notified at Funeral Director | 10e. Street and Number 12008 Iris Av | enue | | 10f. Zip C | ode 215 | 502 | 10g. Citizen d | | intry? | |
| era ar | 11. Marital Status | 12. Was Decedent Ever in | 118 13 | Was Deceder | | | | lace - Ameri | can Indian | |
| | 1 Never Married 2 Married | Armed Forcas?_ | 0,5. | If Yas, specify | Cuban, Mexican, | in? (Specify Yes Puerto Rican, etc | E) B | lack, Whita, | | |
| by Pr. | 3 Widowed 4 Divorced | 1 Yas 2 No If Yes, Giva Year or Datas: | | 1 ☐ Yas 2 ☐ | No Specify: | | Spec | whi | te | |
| led within 72 hours yglene. Nor than "natural", rt, ma Medical E. Completed by | 15. Decedent's E | ducation rade completed) | (Give | dent's Usual C | dona during most | of working | 16b. Kind of | | | |
| lene. | Elementary/Secondary (0-12) | College (1-4or 5+) | | DO NOT use | | | | | | |
| Sept O | 12 | | Form | er Te | chnicia | n | Radio | Stat | ions | |
| Be went | 17. Father's Nama (First, Middla, Las | 1) | | | 18. Mother | 's Nama (First, M | iddle, Maiden Sum | ame) | | |
| fenting of | Richard G. Ma | cey | | | Virg | ginia L | (VanMe | eter) | | |
| oemit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiena. Important: If flem 27 is marked other than any Injury or other treumatic event, that and place. To Be Comp | 19a. Informant's Name/Relationship Barbara Lease | (Type, Print) | | | | r or Rural Routa N 1e; Cumb | lumber, City or Tow | | 21502 | |
| The state of the s | 205. Method of Disposition | 206 | Place of Disp | | | Data | 7 | - Churt | Ctota | |
| 20 H 00 H | 1 Deurial 2 Cremation 3 | | cematary, cre | matory or othe | ar place) | Data | 20c. Locatio | n - City of Ti | Own, Stata | |
| pemit. Pages 'Department of F Important: if Ne any Injury or of price. | 4 Donation 5 Other (Speci | | lendal | e Cem | eteru | 1/2 | O/ Flin | tetor | MD | |
| Semit. Pa Separtmen mportant: iny injury alse. | 21. Signature of Funaral Service Lice | nsee | 2 | 2 Nama and | Addrass of Facility | ineral | O/ Flint Home P. | Δ | , | |
| Depa Park | Malanha d | Anna man. | | Cumbo | rland | Maryla | nd 215 | 02 | | |
| | 23a Part I Enter the disease of con- | unlications that caused the de | eth. Do not en | | | | | J 2 | Approximata | |
| | 23a. Part1. Entar tha disease, or con shock, or heart tailura. List only | one cause on each line. | aur. Do not en | itai bia iliooa t | o oyang, soon as t | saroiac or respirat | ory arrest, | 1 | Interval Between Onset and Death | |
| hysician (Madical | A | | | | | | | 1 | 0.1001 2.10 00011 | |
| /Medical xaminer | tmmediata Cause (Final diseasa or condition | | Nevis | Fibre-0 | tosis | | | 1 | 2 year) | |
| | rasulting in death) | Dua to | Dua to (or as a consequence of): | | | | | - | | |
| - E | The state of the s | | | | | | | | | |
| Pu E | Sequentially list conditions. Dua to (or as a consequence of): | | | | | | | | | |
| S S W | if any, leading to immediata cause. Enter Underlying | | | | | | | | | |
| g physician and as the bunel-transit fedical Examin | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Dua to (or as a consequence of): Dua to (or as a consequence of): | | | | | | | | | |
| £ 5 | resulting in death) Last | Dug to | (Or as a conser | quence or). | | | | | | |
| e ettending physician and ad for use as the buriel-tra | | d | | | | | | | | |
| page 2 should be detached for use Completed by Physician/N | | | | | | | | 1 | | |
| 18 Ped 18 | Part II. Other significant conditions | contributing to death but not re | asulting in tha | underlying cau | sa given in Part t. | 23b. | Did tobecco use | contribute t | to the cause of dea | |
| een signed by the hould be detache steed by Phys | | | | | | | 1 Yes 2 N | 3 Pro | obably 4 Unkn | |
| y d | | | | | | | | | | |
| should should | | | | | | 24a. | Was an autopsy performed? | 24b. W | fere autopsy tinding vailable prior to | |
| | | | | | | | periorinous | CX | ompletion of cause f death? | |
| np mb | | | | | | | | | / | |
| Physicien: The lav this certificate has ral director, page 2 | | | | | | | 1□ Yes 2□No | 1 | ☐ Yes 2 Mo | |
| Bector B | 25. Was case refarred to medicat axaminer? | Hanakati / | | | | of Death (Check | only one) | | | |
| this of the direction o | 1 ☐ Yas 2 ☐ No | Hospital: 1 Inpatient 2 | ☐ ER/Outpatie | nt 3 DOA | Other: 4 Nur | rsing Homa 5 | Residence 6 🗆 | Other (Speci | ify) | |
| ner th | 27. Manner of Death 1 ☑Natural 5 ☐ Pending | 28a. Data of Injury (Month, Day Year) | 28b. Tima o | of 28c | . Injury at Work? | 28d. Desc | cribe how injury occ | berrux | | |
| e for | 2 Accident invastigation | | | | 1 Yas 2 N | 2 No | | | | |
| a effer death. I Director: Affer to a lin by the funeral Certification: | 3 Suicide 6 Could not I | 28a. Place of injury - At noma, farm, street, factory, office | | | office | 281. Location (Street and Number or Rural Rout | | ral Route Number, | | |
| ert in | 4 ☐ Homicide building, atc. (Specify) | | | | | City | City or Town, State) | | | |
| within 24 hours efter death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page. Medical Certification: To Be Com | 29a. Certifier 1 Certifying P | hysician: To the best of my kr miner: On the basis of axamir | nowledge, deat | th occurred at | the time, data and | d place, and due to | o the cause(s) and | manner as : | stated. | |
| Plet Plet | ane) | and mannar stated. | Tation and on it | | my opinion, doub | | mio, oute and plac | 0, 1110 000 1 | .0 0.0 0.200(0) | |
| within to the compound of the | 29b. Signature and titla of continue | 1 | | 29c. L | icense number | | 29d. Data sig | ned (Month, | Day, Year) | |
| 4 | 1 /AP | Mr- C | D. colo | L | Dec- | 220 | T | . 11 | 1000 | |
| | 30. Nama and address of person who | | 1 Raside. | Deint) | 1467 | | Jann | 1-1 16 | 7000 | |
| 4 | | Completed Causa of Ceath (the | ып 238) (Туре, | 1/ (1. | h T. | 11 1 | Itssp.tal | 12 - 11 | 445 | |
| This | David J. Capar. | UIN 600 M: | onnuo | ite sties | 1 1 2 1 2 | c 113 being | 1135/1.600 | 12011 | MIN SIGN | |
| State | 31. Data filed (Month, Day, Year) JAN 1 8 2000 | 32. Registrar's Sign | natura | lan 1 | , | | | | | |
| Registrar | - TO 7000 | Market | NA | works | / | | | | | |

shirt of themen it showed

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First Middle Last) 2. Dete of Deeth 3. Time of Death **Physician** Month Veer MERRILL EUGENE LEASURE 1:45Pm dAna 2000 5 /Medical 4a. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner GOODWILL MENNONITE NURSING HOME GRANTSVILLE GARRETT if Under 1 Yaar If Under 24 Hrs.

Months Deys Hours Min. 5. Sociei Sacurity Number 8. Data of Birth (Month, Day, Year) 7. Aga (In yrs. lest birthday) **Funeral** Birthpieca (Stata or Foreign Country) Deys 1)OM 2□ F Hours Yrs. Director 214-05-8430 OCT 7 1914 MARYLAND the Maryland 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow treumstic event, the Medical Examiner must be notified at MARYLAND ALLEGANY 1 Yas 2 No Director CUMBERLAND 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 8 RFD 3 BOX 834 HAZEN ROAD 238 21502 death Funeral U.S.A. Herns 12. Was Decedent Evar in U,S. Armed Forces? Was Decedant of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuban, Mexican, Puerto Rican, atc.) Race - American Indian, Biack, White, etc. filed within 72 hours after 1 Never Merried 2 Merried 1 ☐ Yas 2 ☑ No If Yes, Give X Yaer or Detes: Baltimore, Maryland 21215-0020 ŏ 1 ☐ Yes 2 ☑ No þ Specify: WHITE 3- Widowed 4 □ Divorced "natural", Completed 15. Decedent's Education 16e. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade complated) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other treumstic event, the second price. Elemantary/Secondery (0-12) College (1-4or 5+) CELANESE CORP OF AMERICA SILK MANUF. 6 17. Fathar's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) FRANK EUGENE LEASURE FLORENCE B. RUSSELL 19e. Informant's Neme/Relationship (Type, Pnnt) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LESTER WILSON STEP SON RFD#3 BOX#60 RIDGELEY, W.VA. 26753 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stata 4 ☐ Donetion 5 ☐ Other (Specify) SUNSET CEMETERY JAN 18 2000 CUMBERLAND MARYLAND 21. Signeture of Funerei Service Licensee 22. Name end Addrass of Facility MERRITT-ADAMS FUNERAL HOME P.A. 23a. Per 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. 404 DECATUR STREET CUMBERLAND MARYLAND **Physician** /Medical Immediate Cause (Final ricular Smin disease or condition resulting in deeth) Examiner Due to (or es e consequence of) Examiner Obstructive 5 years The law requires that the death certificate be executed hysician and the burial-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): P.O. Box 68760. Physician/Medical Due to (or es e consequence of): 88 use Po signed by the at d be detached for Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2⊠No 3 Probably 4 Unknown phlymonia Records, þ 24b. Wara autopsy findings evallable prior to completion of causa of deeth? Completed 24e. Wes an autopsy performed? page 2 certificate 1 ☐ Yes 2 No 1 TYAS 2 No Division of Vital Hospital or Attanding Physician: 25. Wes case referred to medical exeminar? director, Be 26. Plece of Deeth (Check only one) Certification: To 1 Yes 2 No Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpetlent 3□ DOA this funeral 27. Manner of Deeth 28d. Describe how Injury occurred 28e. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? Affer 5 Pending investigation death. 1 Yes 2 No 2 Accident after deat Director: filled in by the 3 Suicida 6 Could not be determined 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Routa Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C completely filled 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end place, end due to the ceuse(s) end menner as stated. edicai 29e Certifier 2 Madical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the ceuse(s) To the 29b. Signeture and fitia of certifier 29d. Dete signed (Month, Day, Year) 10 15, 2000 ddress of person who completed cause of deeth (Item 23e) (Type, Print) MI

ei'

2000

21

32. Registrer's Signature

DHMH 16 Rev 6/95

State

Registrar

31. Data filed (Month Por.

TAMES & SORT Some & STANKE

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of the th 1. Decedent's Name (First, Middle, Last) Month Jan. 10, 2000 **Physician** 10:53 PM Sallye D. Lightfoot /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Southern Maryland Hospital Clinton If Under 1 Year I Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Feb. 23,1906 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplaca (State or Foreign **Funeral** 1 M 2 F Months Days Hours Virginia Yrs. 579-22-2859 93 Director Usual Residence of Decedent with the Meryland r 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Yes 2 No Director Washington, D.C. 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours efter death with I Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumetic event, the Medical Examiner must be in once. 20011 335 Webster Street, N.W. USA Funeral 12. Was Decedant Ever in U,S. Armed Forces? 1 ☐ Yes 2 D No If Yas, Give Year or Dates: Was Decedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian. Black, Whita, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0020 1 Yas 2 No Specify: p **Black** 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT usa retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grada completed) Elementery/Secondery (0-12) Collega (1-4or 5+) 8th Office Secretary 18. Mother's Name (First, Middle, Maidan Surname) 17. Fathar's Nama (First, Middle, Last) Be Sarah Sadler George R. Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Coda) Clinton, Maryland 20735 Eddye Jean Morris/daughter 6827 Groveton Drive 20b. Piece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stata 20a. Melhod of Disposition 1 XBuriel 2 Cremetion 3 Ramoval from State Fort Lincoln Cemetery 1/19/00 Brentwood, Md. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Frazier's Funeral Home, Inc. 389 R.I. Ave., N.W. 20001 Washington, D.C. plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, one cause on each line. Approximate Interval Between Onsat and Death 23a. Part1. Enter its shock, or head **Physician** /Medical Immediate Cause (Final Congestive Heart Failure disease or condition resulting in death) **Examiner** Due to (or es e consequence of): Examiner that the death certificate be executed physicien end s the buriel-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Last Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai Due to (or as a consequence of): 98 980 23b. Did tobacco use contribute to the cause of death? ed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yss 2 No 3 Probably W Unknown Aortic Aneurysm Abdominal 2 5.8 24b. Were autopsy findings available prior to completion of causa of deeth? 24a. Was an autopsy Completed page 2 hes 1 Yes XXNo 1 ☐ Yes 2 No certificete or Attanding Physician: director 25. Was case referred to medical examiner? Be 28. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Xnpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28d. Describe how Injury occurred 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: After 1 X Natural 5 Pending 1 Yes 2 No death. investigation 2 Accident efter deat Director: 6 Could not be determined 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide 24 hours Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier edicai To the Hosp within 24 ho To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigelion, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Data signed (Month, Dav. Year) 29b. Signature and title of certification D53885 1/11/2000 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7501 Surratts Road #307 Clinton, Maryland V.S. Ramanan 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend #'s 21.& 22. Per FH PGC 1-14-2000 cr Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Desth ^{Dey} 2000 JAN. 10, 3:47 PM WILLIAM T. LANGSTON 4b. City, Town, or Location of Deeth 4a Fecility Neme (If not Institution, give street and number) 4c. County of Death PRINCE GEORGE GENERAL HOSPITAL CHEVERLY PRINCE GEORGE If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Deys Min 1 M 2 F Months Hours Yrs. JAN. 12, 1917 N. C. 577-07-2448 Usuel Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No MARYLAND PRINCE GEORGE CAPITOL HEIGHTS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20743 1422 NYE STREET U. S. A. 12. Wes Decedent Ever in U,S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Detes: 14. Rece - American Indian, Black, White, etc. Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Merried 2 Married 1 Yes 2 No Specify: Specify: BLACK 3 ☐ Widowed 4 ☐ Divorcad 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementery/Secondary (0-12) SOCIAL WORKER YEARS 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Neme (First, Middle, Last) **CORNELIA** CHESTNUT WILLIAM A. LANGSTON 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informant's Neme/Reletionship (Type, Print) 1422 NYE STREET CAPITOL HEIGHTS, MD 20743 MILDRED LANGSTON--WIFE 20b. Placa of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, State 20e. Method of Disposition 1 Deurial 2 Cremation 3 Removel from State 4 ☐ Donation 5 ☐ Other (Specify) 1/20/00 ARLINGTON, VA ARLINGTON NATIONAL CEM. 21. Signature of Funeral Service Licens 22. Name and Address of Fecility PINCKNEY SPANCLER FUNERAL HOME J.B.JENKINS FH 524 - 8TH ST., N. E. WASH., D. ADYLANDOVER M. Do not enter the mode of dying, such as cardiac or respiratory errest, buckn 23a. Pert1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Approximete ()/ Intervel Between Onset and Deeth Vessel Disuse Immediate Cause (Final disease or condition resulting in deeth) SLOA Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequence of): Due to (or es e consequence of): 23b. Did tobacco use contributa to the cause of death? Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24a. Wes an autopsy performed? completion of cause of death? 1 Yes 2/□No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical exeminer? 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28c. fnjury et Work? 28d. Describe how injury occurred 27. Manner of Death 28e. Dete of Injury (Month, Day Year) 28b. Time of 1 Naturei 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State)

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Examiner

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State Registrar

Allendin 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) 3001 Hospital Kraig 1 2 2000

32. Registrer's Signeture

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Common On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the

29c. License number

on the besis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner steted.

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29d. Date signed (Month, Day, Year)

Please Type or Print In Black Indelible Ink. Assure Ali Copies Are Legibie. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 3. Time of Death 1. Decedent's Neme (First, Middle, Last) Month **Physician** Donna M. Lauffer Jan. 8 2000 12:17 AM /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4e Fecility Neme (If not institution, give street and number) **Examiner** Doctors Community Hospital Lanham Prince George's If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) **Funeral** Deys Hours 1□M 2□F 180 20 0388 81 Yrs. Director March 8 1918 Pennsylvania Usual Residence of Decedent with the Meryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10e. Stete i le marked other than "naturel", or items 23a or 28a-f ehow traumatic event, the Mooical Examinet mast be notified at ¥ Yes 2 No Maryland Prince George's Directo Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 12605 Millstream Drive 20715 United States death 1 Funeral 12. Wes Decedent Ever In U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. filed within 72 hours efter Hygiene. 1 Yes 2000 No If Yes, Give Yeer or Detes: 1 ☐ Never Married 2 ☑ Merried Specify: White 1 Yes 2 No Specify: à 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 end 2 should be filed within 7. Depertment of Health and Mental Hygiene. Important: If item 27 is marked other than "na eny injury or other traumatic event, the Medic page. Prince George's Elementary/Secondary (0-12) College (1-4or 5+) Teacher Public Schools 12 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Harry E. McWilliams Annie E. Hobaugh 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) 12605 Millstream Drive Bowie Maryland 20715 Robert Lauffer Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Jan. 20c. Location - City or Town, State 20e. Method ot Disposition 13, Date 2000 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removel from State Maryland Veterans Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Cheltenham Maryland 22. Name end Address of Fecility 21. Signeture of Funerel Service Licenses Robert E. Evans Funeral Home, Inc. 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest,

Approximate Intervel Between Onset end Deeth Physician /Medical immediete Ceuse (Finel disease or condition resulting in deeth) **Examiner** Examiner that the death certificate be executed attending physician end for use es the buriel-trensit Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Diseese or injury that initieted events resulting in death) Lest 28 Physician/Medical Due to (or es e consequenca ot): 23b. Did tobacco use contribute to the cause of death? ed by the detached Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by to 3 Probably 4 ∰ bnknown 1 ☐ Yee 2 ☐ No þ 24b. Were eutopsy findings evailable prior to been si 24a. Wes an eutopsy performed? Completed completion of cause of death? has 1 Yes 2 1 NO 1 ☐ Yes 2 ☐ No certificate 25. Wes case reterred to medical examiner? Be 26. Piece of Deeth (Check only one) Hospitel: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient 2 2 ER/Outpetient 3 DOA this funeral 27. Manner of Deeth Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? Certification: After or Attending 5 Pending investigation 1 Tyes 2 No death. Director: A 2 Accident 6 Could not be determined 28t. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Sulcide 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homlcide • Funeral Dire letely filled in b 29e. Certifier Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and piece, and due to the cause(s) and menner as stated. edical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. (Check only one) within 2 To the 29d. Date signed (Month, Day, Year) 29b. Signeture end title of certifier 29c. License number

To the within

Division of Vital Records, P.O. Box 68760,

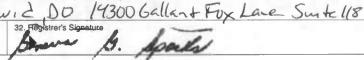
Baltimore, Maryland 21215-0020

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State Registrar 31. Dete tiled (Month, Day, Year)

JAN 1 2 2000

30. Neme end eddress of person who completed cause of death (Item 23a) (Type, Print)



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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 10:35 AM 6, 2000 trances January /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Regional Hospital Prince George's Laurel Laurel 8. Date of Birth (Month, Day, Year)
Dec 22, 1930 If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1□ M 200 F Months Days Hours Min. 69 NC Director 577-38-8081 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits 28a-f show 7 is marked other than "natural", or items 23s or 28s-f shor traumatic event, the Modical Examiner must be notified as Yes 2 No Directo Prince Georges Lanham 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 6413 Princess Garden Parkway 20706 U.S.A. filed within 72 hours after death v Hygiene. ther than "natural", or items 23 Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 XXVo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify Specify: White by 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondery (0-12) College (1-4or 5+) 12 years Secretary Bluebird Cab Co. permit. Pages 1 and 2 should be file Department of Health and Mental Hyg Important: If flem 27 is marked other any injury or other traumatic event, DDCs. 18. Mother's Name (First, Middle, Meiden Sumame) 17. Father's Name (First, Middle, Last) Frank A. Werner Martha D. Hicks 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informant's Name/Relationship (Type, Print) 6413 Princess Garden Pkwy Lanham, MD 20706 Joyce Butler - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Jan 10. 1 Burial 2 Cremation 3 Removal from State Ft. Lincoln Cemetery 4 Donation 5 Other (Specify 2000 Brentwood, MD 22. Name and Address of Facility 21. Signature of Funeral Service Liver Rendon/Hale Funeral Home 9013 Annapolis Rd. Lanham, MD 20706 Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Ashock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** Immediete Ceuse (Final disease or condition resulting in death) /Medical 3 months · Bronchogenic Carcinoma Examiner Due to (or es e consequence of): Examiner Chronic Obstructive Pulmonary Disease 10 years attending physician and for use es the bunal-transit law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Acute Myo cardial Infarction
Due to (or as a consequence of): Box 68760, Physician/Medical 159 esn Coronary Artery O. seas 23b. Did tobacco use contributs to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy performed? peen completion of cause of deeth? hes 1 Yes 2 No 1 ☐ Yes 2 ☐ No carificate 25. Wes case referred to medical examiner? Be 28. Place of Deeth (Check only one) Hospital: 1 Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No 2 funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how Injury occurred Certification: Affac Neturel Accident Attending 5 Pending 1 Yes 2 No investigation after death Director: / 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide A Paneral D Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.

Madical Examiner: On the basis of exeminetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. edical 29a, Certifier To the To the To the Foomplet 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name of address of person who completed cause of deeth (Item 23e) (Type, Print) 1-7-00 00012015 Steinberg, MD. 6492 LandoverRd, Landover Mp 20785

State Registrar 31. Date filed (Month, Day, Year)

JAN 1 0 2000

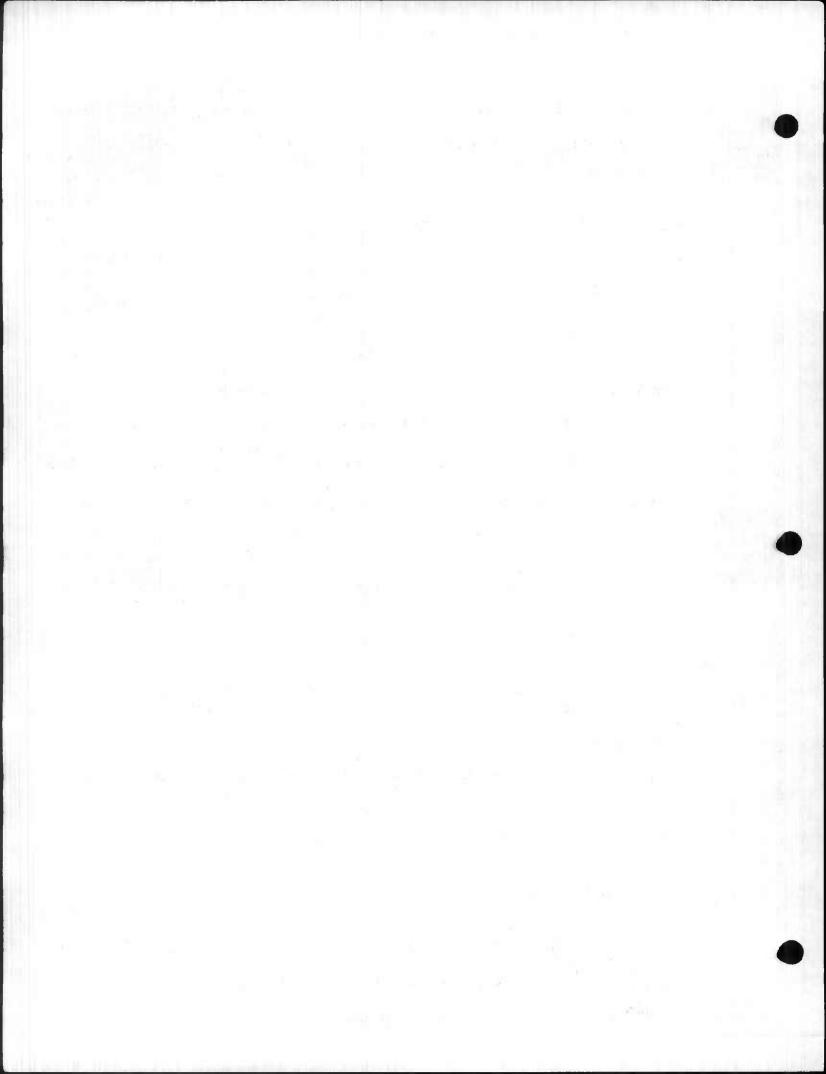
32. Registrar's Signature

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State of Maryland / Department of Health and Mental Hygiene o o

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| | Physic | ian | 1. Decedent's Name (First, Middle, Last |) | | | | 2. Date of Dear Month | th Day Year | 3. Time of Death | | |
| | /Medi | | Blanche Catherin | e Leschefsky | | | | January | | 22:45 | | |
| | Exami | | 4a. Facility Name (if not institution, give | street end number) | | | 4b. City, Town, or Lo | ocation of Death | 4c. County of Dea | th | | |
| | | | Union Hospital o | f Cecil Coun | ty | | E1kton | | Cecil | | | |
| Г | Funerai | | Social Security Number 6. Security Number | | s. last birthday) | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day) | Vegri 9. Bir | thplece (State or Foreign buntry) | | |
| | Director | | 212-36-/188 | M 2⊠F 60 | Yrs. | Duys | TIOUIS IVIII. | August | 4, 1939 Man | ryland | | |
| | pu . | | Usual Residence of Decedent 10a. State 10b. County | 10- | Oh. T | | | | | | | |
| | ahow | - | Toa. State | 100. | City, Town or Lo | cation | | | | 10d. Inside City Limits | | |
| | M Self | Director | Maryland Cecil | E | 1kton | | | | | 1 ☐ Yes 2 🕅 No | | |
| | ₩ 2 × × | - in | 10e. Street and Number | | | 10f. Zip Code | | 1 | 0g. Citizen of What Co | ountry? | | |
| | 23a | a | 187 Woods Way | | | 21921 | | | United Sta | tes | | |
| | ems | Funeral | 11. Marital Status | 12. Was Decedent Ever In Armed Forces? | U,S. 13. V | Vas Decedent of I | Hispanic Origin? (Sp an, Mexican, Puerto | ecity Yes or No- | 14. Raca - Ame Black, Whit | | | |
| 20 | 72 hours after deeth with the Maryland netural; or items 23s or 28s-f show dest Examiner must be notified at | F | 1 Never Married 2 Married | 1 ☐ Yes 2 🔯 No If Yes, Give | | ☐ Yes 2☑ No | | t tiouri, oto.) | Specify: | e, etc. | | |
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| Maryland | 2 2 2 | Be | 17. Father's Neme (First, Middle, Last) | | | | 18. Mother's Name | | Meiden Sumeme) | | | |
| N N | should be nd Mental marked o | 2 | John Dorn | | | | Blanche | | | | | |
| Mai | 0 8 8 2 | | 19a. Informent's Neme/Relationship (Ty | | | | | | , City or Town, Stele, | Zip Code) | | |
| | こことと | | John F. Leschefsky | | | | y, Elkton | - | | | | |
| O | N H O | | 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ R | | . Placa of Dispos cemetery, crem | sition (iveme of setory or other ple | ce) Jar | Date nuary | 20c. Location - City or | Town, State | | |
| Ë | | | 4 ☐ Donation 5 ☐ Other (Specify) | | 11y Hill | L Memoria | | | Baltimore, | Maryland | | |
| Baltimore, | pemit. Pag Department Important: If eny Injury o | | 21. Signature of Funeral Service License | 19 | 22. | Name and Addre | ess of Facility | | | | | |
| ш | 20529 | | 1 Kole D 1 1 | me | | | neral Home | | th Fact Ma | ryland 21901 | | |
| | | | 23a. Part1. Enter the disease, or compli | cations that caused the de | ath. Do not ente | or the mode of dyl | ng, such as cardiac | or respiratory arre | est, | Approximate Interval Between | | |
| | Physician | | 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. | | | | | | | | | |
| ш | /Medical | | Immediate Cause (Final disease or condition | MACC | Socirchal in Grober mi | | | | | | | |
| | Examiner | | resulting in death) | Due to | (or as a consequ | uence of): | | | | | | |
| _ | D # | Examiner | | Sovere | - 150 | mmic | can | wany | barthy | YPPIN | | |
| | ificate be axecuted g physician and as the burial-transit | am | Sequentially list conditions, | Due to | (or as a consequ | uenca of): | (0,7) | 70. | | 000 | | |
| Ő, | lan a | ũ | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | | | | | | | | | |
| 68760, | physic the b | edicai | Cause (Disease or injury thet initiated events resulting in death) Last | Due to | (or as a consequ | ience of): | | | | | | |
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| Box | the death cert y the ettendin ached for use | Physician/N | | l | | 1.55 | | | | | | |
| | dea be ett | sici | Part U Other significant conditions con | tributing to death but not re | esulting In the un | derlying cause gi | ven in Part I. | 23b. Dld to | bacco uas contributs | to the cause of death? | | |
| P.0 | thet the de led by the e detached t | h, | I hat he hope | | | | | NOY | 8 2□ No 3□P | robably 4 Unknown | | |
| | ires thet signed b | by F | Dances |) | | | | | | | | |
| Records, | | | restman | | | | | 24a. Was a | | Were autopsy findings available prior to | | |
| 00 | > 11 00 | Completed | 112001 | -01 | | 1 | 1 | perform | | completion of cause of deeth? | | |
| Ä | iclen: The lav certificate hes rector, page 2 | E O | (Inversión (| MX Za | NHIL | NIN | n disa | 1□ Ye | 98 2 NO | 1 ☐ Yes 2 ☐ No | | |
| Vital | iffical | Be C | 25. Was case referred to medical | | 000 | _ 01/1 | 26. Place of Deetl | - | | 12 100 22 100 | | |
| 5 | ysician: Is certific director, | To B | examiner? | lospital: 1 Inpatient 2 | ☐ ER/Outpatient | 3 DOA OU | nor: | | enca 6 □Other (Spe | oih) | | |
| o | Phys or this eral di | | 27. Manner of Deeth | 28a. Date of Injury (Month, Dey Yeer) | 28b. Time of | 28c. Inju | | | ow injury occurred | Cny) | | |
| lo | tending Ph leeth. tor: After th the funeral | tio | 1 ☑ Naturel 5 ☐ Pending 2 ☐ Accident Investigation | (Month, Dey Yeer) | Injury | | rk? Yes 2 □ No | | | | | |
| Division | Attending Physician: or death. actor: After this certific by the funeral director, | Certification: | 3 ☐ Suicide 6 ☐ Could not be | 28e. Placa of Injury - At | home, farm, stre | et, factory, office | | | reet and Number or Ru | ural Route Number, | | |
| ă | or effe | ert | 4 Homicide | building, etc. (Spec | cify) | | | City or Town | n, Stete) | | | |
| | Hospital 24 hours e Funeral I | | 29a. Certifier 1 CertifyIng Phys | ician: To the best of my kr | nowledge, deeth | occurred at the ti | me, dete and place. | and due to the ca | ause(s) end manner as | s stated. | | |
| | To the Hospital or Attenwithin 24 hours effer deet To the Funeral Director: completely filled in by the | edical | (Check only one) Examir | ner: On the basis of examir and manner stated. | nation and/or inve | estigation, in my o | ppinion, deeth occurr | ed at the time, de | ate and place, and due | to the ceuse(s) | | |
| | withir To th | Me | 29b. Signature and title of certified | 1/11 | | 29c. Licens | se number | | 9d. Date signed (Mont | | | |
| | | |) //////////////////////////////////// | 11/12/11/1 | NO | 100 | 15155 | (| 21/13/ | 2000 | | |
| | 1000 | | 30. Name and address of person who co | moleted cause of death (its | om 23a) (Tuno 5 | Print) | ,,,,, | | | | | |
| | 15 | | John Mulvey MD, 11 | | | | Maruland | 21021 | | | | |
| | Sta | te | 31. Date filed (Month, Dey, Year) | 32. Registrar's Sig | | TIKCUII, | narytand | 717/I | | | | |
| | - Jia | | IAN 1 4 2000 | 24 | 4 | / | | | | | | |



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| | | | Certi | ficate of | Death | | Reg. No. | U | 2310 |
|--|--|---|--|--|---|--|------------------------------------|--|---|
| Physician | 1. Decedent's Name (First, Middle, L | | | | | 2. Date of D Month | Day | Year | 3. Time of Death |
| /Medical | Dorothy | Thomas | Lee | | | Jan. | |)000 | 11:55 AM |
| Examiner | 4a Facility Name (If not institution, g | Charles Services and | | | | or Location of Dea | , | | |
| | Anne Arundel Medica | | | If Under 1 Year | Annapo] | | | Arunde | |
| Funeral Director | 220-46-6327 | Sex 1 □ M 2 1 F 7. Age (In y | | Aonths Days | | in (Month D | 8, 1909 | Countr | ce (State or Foreign y) gton D.C. |
| pue * | Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location | | | | | | | | d. Inside City Limits |
| or 28a-f aho be noutled | Maryland Anne A | | Annapolis | | | | | | 1 ☐ Yes 2 No |
| 23a or 2 | 10e. Street and Number 731 Robin Hood Hil. | | | 10f. Zip Code 2] | 1405 | | 10g. Citizen of V | What Countr State: | |
| 72 hours after death with the Maryland natural, or items 23s or 28s-f show diest Examiner must be notified at sted by Funeral Director | 11. Marital Status 1 Never Merried 2 Married 3\(\) Widowed 4 Divorced | 12. Was Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: | | s Decedent of hes, specify Cub | lispanic Origin? an, Mexican, Pu Specify: | (Specify Yes or Nerto Rican, etc.) | Specify | e - America ck, White, et : : White | c. |
| ed within 72 hours yglene In the Medical En- Completed by | 15. Decedent's I (Specify only highest g | | (Give kin | it's Usual Occup of of work done | during most of v | vorking | 16b. Kind of Br | | |
| then. | Elementary/Secondary (0-12) | College (1-4or 5+) | | NOT use retire | d) | | | | |
| Hied v Hygie Ther th | 17 Fethada Nama (First Middle Lau | 4 | ŀ | lomemaker | 40. 84-15-1-1-5 | Laure d'Erret Adulett | | me | |
| SES W | 17. Father's Name (First, Middle, Las William J. G. The | | | | | lame (First, Middle Robbins | , Maiden Suman | 10) | |
| 2 9 9 2 | 19a. Informant's Neme/Reletionship | | | | | Rural Route Numb | | | |
| lead m 2 ther | Jerry Lee / Sol | | /54 KOD D. Place of Dispositi | | ill Sherv | vood Forest | Annapolis 20c. Location - | - | |
| 852 | 1 ☐ Burial 2 ☐ Cremetion 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Control | Removel from Stete | cemetery, cremat | ory or other ple Cemetery | , | 01-18-00 | Rockvill | | |
| permit. Pages Department of Important: If it any injury or ang injury or | 21. Signature of Funeral Service Lips | nsoo D | | lame end Addre | | John M. Ta | | | |
| | 23a. Part1. Enter the disease, or cor shock, or heart feilure. List on | nplications that caused the de | | | | ster Street liac or respiretory | | : / | 21401 Approximate Interval Between |
| Physician /Medical | Immediate Cause (Finel | 1 2 | | | | _ | | | Onset end Deeth |
| Examiner | disease or condition resulting in death) | a. Howe | KCSPII | nce of): | 24 19 | lure | | | 1-2d |
| executed in and isl-transit | | b. HSPIR. | TION. | PNEW | HONIA | 7 | | | 3-5d |
| | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | STAP H | for as a conseque | nce of): EUS — | SEPS/S | | | | 3-5d |
| 20 01 11 20 | that initiated events resulting in death) Last | UT | (or as a consequent | | Lin Gra | (in) | | | 3-5d |
| at the death cert by the attendinestached for use | | d | CHILIM | gray | Mila | corj | | | |
| the att hed for | Part II. Other significant conditions | contributing to death but not r | resulting in the unde | orlying cause give | ven in Part I. | 23b. Dld | tobacco use co | ntribute to t | he cause of death? |
| signed by the dobe detached by Physis | CHF, HTT | V, HYPOT | HYRO | DISU | И | 10 | Yes 2 10 | 3 Probe | ably 4 Unknow |
| been shoul | | | | | | | an autopsy ormed? | avai | e eutopsy findings lable prior to pletion of cause eath? |
| The law page 2 | | | | | | 10 | Yes 2 No | | Yes 2 No |
| | 25. Was case referred to medical | | | | OC Diago of I | | | 10 | 163 20140 |
| Physician: ribis certific ral director, r: To Be (| examiner? | Hospital: 1 Inpatient 2 | ☐ ER/Outpatient | 3 DOA Ott | ner. | Deeth (Check only Home 5 Res | | or (Enosiki) | |
| | 27. Manger of Deeth | 28a. Date of Injury | 28b. Tima of | 3LI DON | 4LI Nursing | 1 | how injury occur | | |
| Hospital or Attending P 24 hours after death. Funeral Director: After total filled in by the funeral director. After total filled in by the funeral dical Certification: | 1/SNatural 5 Pending 2 Accident investigets 3 Suicide 6 Could not | (Month, Day Year) Injury Work? | | | rk? Yes 2□No | 28f. Location (Street and Number or Rural Route Num | | S | |
| alor As after a li Director by the Certif | 4 Homicide determined | building, etc. (Spe | t home, term, street ocify) | , tectory, office | | 251. Location (Street end Number or Hural Houte Nu City or Town, State) | | Noute Number, | |
| Hospi 24 hour Funer stely fill | 29a. Certifier (Check only one) Certifying P | hysician: To the best of my k miner: On the basis of exami and manner stated. | nowledge, death or ination and/or inves | curred at the til tigation, in my c | me, date end ple opinion, deeth oc | ce, and due to the coursed at the time | cause(s) end ma date end place, | anner as sta and due to t | ted. he cause(s) |
| To the within 7 To the comple | 29b. Signature and title of certifier | M | | 29c. Licens | se number | 2 | 29d. Date signe | d (Month, D | ay, Year) |
| | 30. Name and address of person who | completed cause of death (III | lem 23a) (Type, Pri | | | | 01/13/ | 00 | - / |
| | ANDREW GORD | | 3 Medica | 1 Phone | y Suite | 100 An | nepolis M | ld e | 21401 |
| State Registrar | 31. Date filed (Month, Day, Year) | 22. Regulatron's Sig | mature A | food | , | | | | |
| HMH 16 Rev 6/95 | - | /- | 1 | HURA | 2 | | | | |

Sheeffi . A more Door 8 I HAL

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month

| | | Physic /Medi Examii | cal |
|--------|--|--------------------------------------|--------------------------|
| I | | uneral irector | |
| 5-0020 | 72 hours efter death with the Meryland | naturel', or items 23s or 28s-f show | eted by Funeral Director |

1 M 2 TF 62 Apr 2. 1937 212-36-4041
Usuel Residence of Decedent 10a. State 10c. City, Town or Location 10b. County Finksburg Maryland Carroll 10e. Street and Number 10f. Zip Code 21048 2888 Constellation Way USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Peges 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: if item 27 is marked other than "nat any injury or other traumatic event, the Median once. altimore, Maryland 2121 Compl Elementery/Secondery (0-12) College (1-4or 5+) Homemaker 17. Father's Name (First, Middle, Last) 18. Mother'a Name (First, Middle, Maiden Sumame) Michael Haloskey Angeline Mastrangelo 19a. Informant's Name/Relationship (Type, Print) John H. Mummert (Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Carroll Cremation Inc 1-18 21. Signature of Funeral Service Licent 22. Name and Address of Facility **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner abscess todominal death certificate be executed sician and buriel-frans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760 ettending physician Physician/Medical Due to (or as a consequence of) the 98 1 esn Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 0.0 Pulmonary infarct Division of Vital Records, þ Completed History of bladder cancer 24a. Wes an autopsy performed? 1 Nes 2 No 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) funeral 27. Menner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation I or Attending safter death. I Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 24 hours a Funeral D edicai 29a. Certifier completely (Check only one) within 2 To the 29c. License number 29b. Signature and title of certifier no

16, 200b 0255 January BARBARA JOAN MUMMERT 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Carroll Westminster Carroll County General Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Illinois 10d. Inside City Limits 1 Yes 2 No 10g. Citizen of What Country? 14. Race - American Indian. Black, White, etc. White 16b. Kind of Business/Industry Own Home 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2888 Constellation Way Finksburg, MD 21048 20c. Location - City or Town, State Hampstead, Maryland Pritts Funeral Home and Chapel, P.A. 23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21157 Approximate Interval Between Onset and Death 23b. Did tobacco usa contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of deeth? 1 PYes 2□ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 🗹 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, and due to the cause(s) and manner as stated. 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) JANUARY 17, 2000

State Registrar 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

ENRICO A. GIANGERUSO, MD

200 MEMORIAL AVE.

WESTMINSTER, MD

Arthur and a second of the sec State of the state of the state of the et a class a lifet and Europe Latin Seas

Please Type or Print in Biack Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death Time of Death Day Month Year 5:20 PM January 12, 2000 Robert Adrian Meachem 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel Hundar 24 Hrs. 8. Data of Birth (Month, Dey, Year) Min. March 24, 1949 If Under 1 Year 9. Birthplace (Stata or Foreign Country) New York 5. Social Security Number Sex MM 2□ F 7. Aga (In yrs. last birthday) Months Days Yrs 214-56-0867 50 Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Queen Anne's Stevensville 1 ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 506 Love Point Road 21666 USA 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yas 20 No If Yes, Giva 14. Race - American Indian, 11 Marital Status Black, Whita, atc. 1 Nevar Married 2 Married 1 Yes XXNo Specify: Specify: White 3 Widowed ANDivorced Yaar or Datas: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Collega (1-4or 5+) Construction Painter 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Meidan Surnama) Robert E. Meachem Lucienne Pierrard 19e. Informant's Name/Ralationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 506 Love Point Rd. Stevensville, MD Gloria Meachem - Sister 20b. Place of Disposition (Nama of cematary, cremetory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☐ Burlal 2 Cramation 3 ☐ Ramoval from Stata Chesapeake Cremation Center January 14,2000/Stevensville 4 ☐ Donation 5 ☐ Othar (Specify) 21 Signature of Funeral Service Licente 22. Nama and Addrass of Facility Fellows, Helfenbein & Newnam Funeral Home ons that causad tha death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, use on each line. Chester, MD 21619 23a. Part 1. Entar tha diseasa, or com shock, or haart fallura. List only Approximate Intervat Between Onset and Death Immediata Causa (Final diseese or condition rasulting in death) OSIS Sequentially list conditions, if any, laading to immadiata cause. Entar Undarlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Dua to (or as a consequence of): 23b. Did tobacco usa contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 Ne 3 Probably 4 Unknown 1 Yea 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 20 No 1 ☐ Yas 1 □ Yas 25. Was case refarred to medical examinar? 26. Place of Deeth (Check only ona) Hospitel: Linpatient Other: 4 Nursing Homa 5 Rasidance 6 Other (Specify) 2 ER/Outpatient 3 DOA

Physician /Medical Examiner

and

attending physician

Box 68760

Division of Vital Records, P.O.

or Attending Physician:

this

After

completely

death.

To the F within 2

Physician

/Medical

Examiner

Funeral

Director

"natural", or flams 23s or 28s-f show

Hygiens.

permit. Pages 1 and 2 should be fits.
Department of Health and Mental Hy important: if New 27 is merced offer any Injury or other treatment of the

72 hours after

altimore, Maryland 21215-0020

must be notified at

Director

Funeral

À

Completed

Be

Examiner the signed by t page 2 s luneral Director: / n 24 hours after de Funeral Directo pletely filled in by the

Physician/Medical by Completed 86 Certification: To

edical

27. Manner of Death Natural

1 Yas ZENO 5 Pending

2 Accident invastigation 6 Could not be detarmined 3 Suicida 4 I Homicide

28a. Data of tnjury (Month, Day Year)

28b. Time of 28a. Placa of Injury - At home, farm, street, factory, office building, atc. (Specify)

28c. Injury at Work? 1 Yas 2 No

28d. Dascribe how injury occurred

28f. Location (Street and Number or Rural Routa Number, City or Town, Steta) **Description of the best of my knowledge, death occurred at the time, deta and place, and dua to the cause(s) and manner as stated.

2 Medicat Examinar: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signatura and title of certifiar

30. Nama and addrass of person

NU

who complated causa of death (Item 23a) (Type, Print)

29c. License number

29d. Data signed (Month, Day, Year)

31. Data filed (Month, Day, Year) State

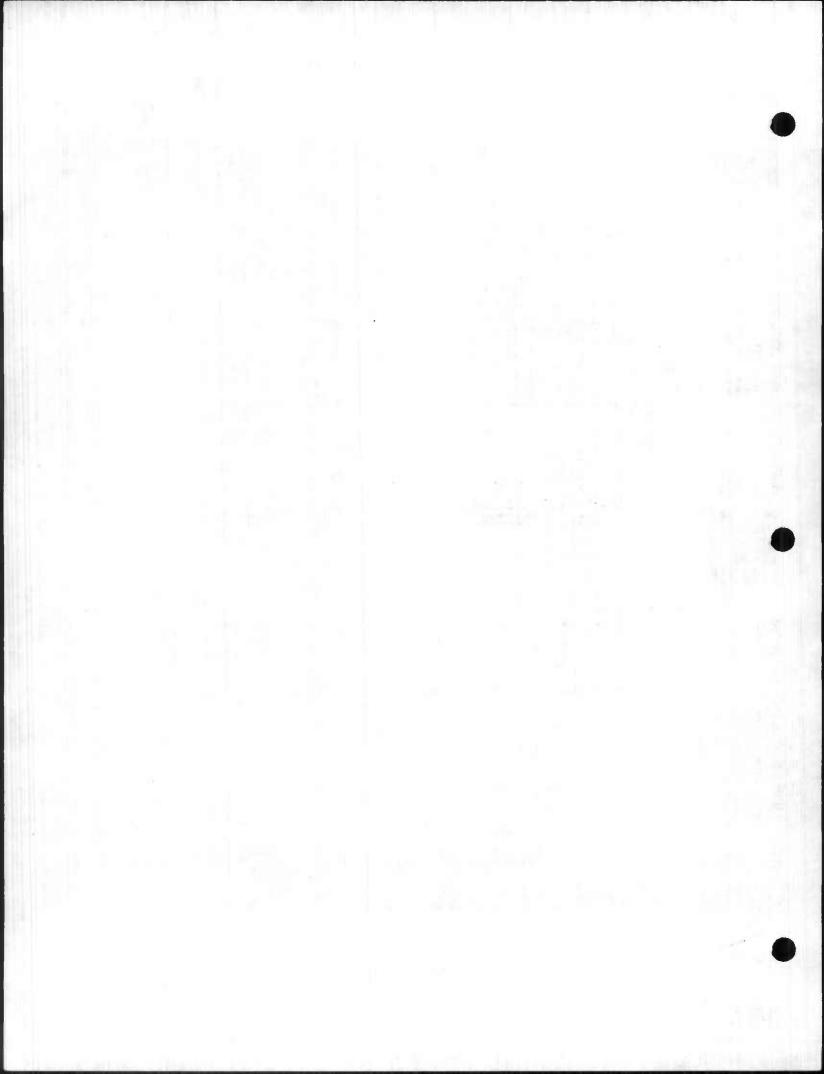
29a. Cartifian

(Check only one)

32. Registrar's Signeture

DHMH 16 Ray 6/95

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Jan 14, Day **Physician** Stephen Patrick Malloy 2000 04:10pm /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner 550 Greene Street Cumberland Allegany If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth | Nonths | Days | Hours | Min. | Jan | 25, 1950 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 M 2□F 212-54-8236 49 Yrs **Director** Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other treumstic event, the Modical Examiner must be notified at 1 Yes 2 No Directo MD Allegany Cumberland 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 550 Greene Street 21502 USA 2 should be filled within 72 hours after death in and Mental Hygiene.
Is marked other than "natural", or frems 23 Funeral 12. Wes Decedent Ever in U,S. Agmed Forces? ≠∑ Yes 2 No If Yes, Give Year or Dates Vietnam Was Decedent of Hispanic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Rece - American Indian. 11. Maritel Status Black, White, etc. Never Married 2 Married 1 Yes 2 No Specify: altimore, Maryland 21215-0020 Specify: white b 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 4 Assessor State of Maryland 18. Mother's Name (First, Middle, Meiden Sumame) 17. Fether's Name (First, Middle, Last) Edward A. Malloy, Sr. Joy (Lane) 19a. tnformant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, permit. Pages 1 and 2 st Department of Haaith and important: if Item 27 is n any Injury or other treun once. Edward & Joy Malloy 550 Greene Street; Cumberland, MD 21502 Parents 20a. Method of Disposition 20b. Placa of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from Stete 4 ☐ Donation 5 ☐ Other (Specify) SS Peter Paul Cemetery1/18/ Cumberland, MD 21. Signature of Funeral Service Licensee 25 Carpelli Fruneral Home P.A. Cumberland, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Finei disease or condition resulting In death) /Medical a Carcinoma of colon, metastases to the liver Examiner Due to (or as a consequenca of): Examiner attending physician and for use as the burial-transit requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of) 88 use a 23b. Did tobacco use contributs to the cause of death? Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. signed by t 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed page 2 has 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical exeminer? 26. Place of Death (Check only one) Be 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28d. Describe how injury occurred 28c. injury at Work? 28b. Time of Certification: 1 Dalatural 5 Pending s after death. 1 TYes 2 No 2 Accident investigation 6 ☐ Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 4 Homlcide

To the Hospital within 24 hours a within 24 hours I To the Funeral I completely filled

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
Uriel E Velandia M.D. 902 Seton

dia M.D. 902 Seton Drive Cumberland MD 21502

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D08377

29d. Date signed (Month, Day, Year)

Jan 19, 2000

State Registrar 31. Date filed (Month, Day, Year)

29b. Signature and title of certiling

29a. Certifier

(Check only one)

JAN 1 9 2000

32. Registrar's Signature

eece



JAN 18 2000 January & The second

Certificate of Death

Item 27 is r other tra = 8) opartmont

Box 68760. P.O. Records, Vital

216-22-6540 of MERRITT Division Attending death. ò Hospital 4

1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Tima of Death Month Dav **Physician** ROY WILLIAM EDWARD MERRITT 15. 2000 /Medical January 5:45 A.M. 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Memorial Hospital & Medical Center Cumberland Allegany If Under 24 Hrs. Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Birthplace (State or Foreign Country) **Funeral** Months Days 1 € M 2 □ F 216-22-6540 71 Director 1AY 23 1928 MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 √ Yes 2 No Directo ALLEGANY CUMBERLAND 288-71 MARYLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? b 21502 20 MULLIN STREET U.S.A. therns 23a Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Raca - American Indian, Bleck, White, etc. 11 Marital Status 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 b 1 ☐ Yes 2 ☐ No Specify: 'n WHITE 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. filled within Elementary/Secondary (0-12) College (1-4or 5+) CSX RAILROAD CRANE OPERATOR 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be nent of Health and Mental ROY LELAND MERRITT CLARA BAER 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BARBARA MERRITT WIFE 20 MULLIN STREET CUMBERLAND MARYLAND 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CUMBERLAND CREMATORY JAN 16 2000 CUMBERLAND MARYLAND 21 Signature of Fugeral Service Licens 22. Name and Address of Facility MERRITT-ADAMS FUNERAL HOME P.A. di 404 DECATUR STREET CUMBERLAND MARYLAND 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Finel /Medical 7 days disease or condition resulting in deeth) Hepatic Encephalopathy Examiner Due to (or as a consequence of): Examiner 3 years Cirrhosis of Liver Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical the Due to (or as a consequence of): for use iigned by the a Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Pres 2 No 3 Probably 4 Unknown Dehydration Signed by 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Wes an autopsy performed? peen has page 2 certificate 1 Yes 2 No 20 No funeral director, 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Nnpatient Certification: To 1 Yes 2 No 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Menner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident after death Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 4 - Homicide filled in within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner state(s).

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner state(s). 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MID 16th D 23334 2000 January 30. Neme and address of person who completed cause of death (Item 23a) (Type, Print) 625 Kent Avenue, Suite 205 nus Dr. Shah, Johnson Heights Medical Building Cumberland, MD 31. Date filed (Month, Day, Year)
JAN 1 8 2000 32. Registrar's Signature State Registrar

DHMH 16 Ray 6/95

MALLS 2000 Some & Miner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth Month OLA MARIE MULLIKIN 7, 2000 1:50p.m. January 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Talbot The Memorial Hospital at Easton Easton If Under 1 Yeer | If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) Min. 1 M 2 KF Months Days Hours 82 APRIL 17,1917 MARYLAND 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Nes 2 No TALBOT EASTON 10f Zin Code 10g. Citizen of What Country? U.S.A. 201 FEDERAL STREET, # 26 21601 12. Wes Decedent Ever in U.S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🗓 No If Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify 3 X Widowed 4 ☐ Divorced WHITE Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) STORE KEEPER **GROCERY** 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumame) WILLIAM JAMES CAULK MAGGIE COLLINS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) WILLIAM EDWARD MULLIKIN/SON 503 DECATUR PLACE, EASTON, MD 21601 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donetion 5 Other (Specify) CHESAPEAKE CREMATION CENTER 1/8/2000 CHESTER, MD Pineral Service License 22. Name and Address of Facility FELLOWS, HELFENBEIN, & NEWNAM FUNERAL HOME, 200 SOUTH HARRISON STREET, EASTON, MD 21601 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Deeth Pulmonary 48 Ws Due to (or as a consequence of) Due to (or as a consequenca of)

Physician /Medical Examiner

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signed by the a

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After

n 24 hours after death • Funerel Director: A pletely filled in by the f

completely To the Vithin 2

death.

ò Hospital

that the death certificate be executed

Box 68760.

P.O.

Records,

Division of Vital Attending Physicien:

The law requires

Physician/Medical Examiner

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Completed

Certification: To Be

Medicai

Physician

/Medical

Examiner

Funeral

Director

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"neturel", or flems 23e or

Hygieria.

L. Pages 1 and 2 should be flied in trinent of Health and Mental Hygier tant: if Item 27 is marked other th jury or other traumatic event, the

Saltimore, Maryland 21215-0020

5. Social Security Number

Usual Residence of Decedent

Elementary/Secondery (0-12)

20e. Method of Disposition

064-26-2955

10e Street and Number

10a. State

MD

Director

Funeral

þ

Completed

Be

Immediate Cause (Finel

disease or condition resulting in death)

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last

23b. Did tobacco use contribute to the cause of death?

1 Yss 2 No 3 Probably 4 Unknown

24e. Was an autopsy performed?

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

28. Place of Death (Check only one)

1 ☐ Yes 2 ☐ No

25. Was case referred to medical axaminer? 1 Yes 25 No 1 Inpatient 2 ER/Outpatient 3 DOA

28a. Date of Injury (Month, Day Year)

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

28b. Time of 28c. tnjury at Work?

Other: 4 Nursing Home 5 Residence 8 Other (Specify)

28d. Describe how injury occurred 1 Yes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier

27. Menner of Death

1 Netural

2 Accident

3 Suicide

4 Homicide

12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated.

29b. Signeture end title of certifier

29c. License number D 36909 29d. Date signed (Month, Day, Year) 1-7-00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SUSAN T. FORLIFER, M.D. 505 DUTCHMAN'S LANE, EASTON, MD 21601 31. Date filed (Month, Day, Year)

28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

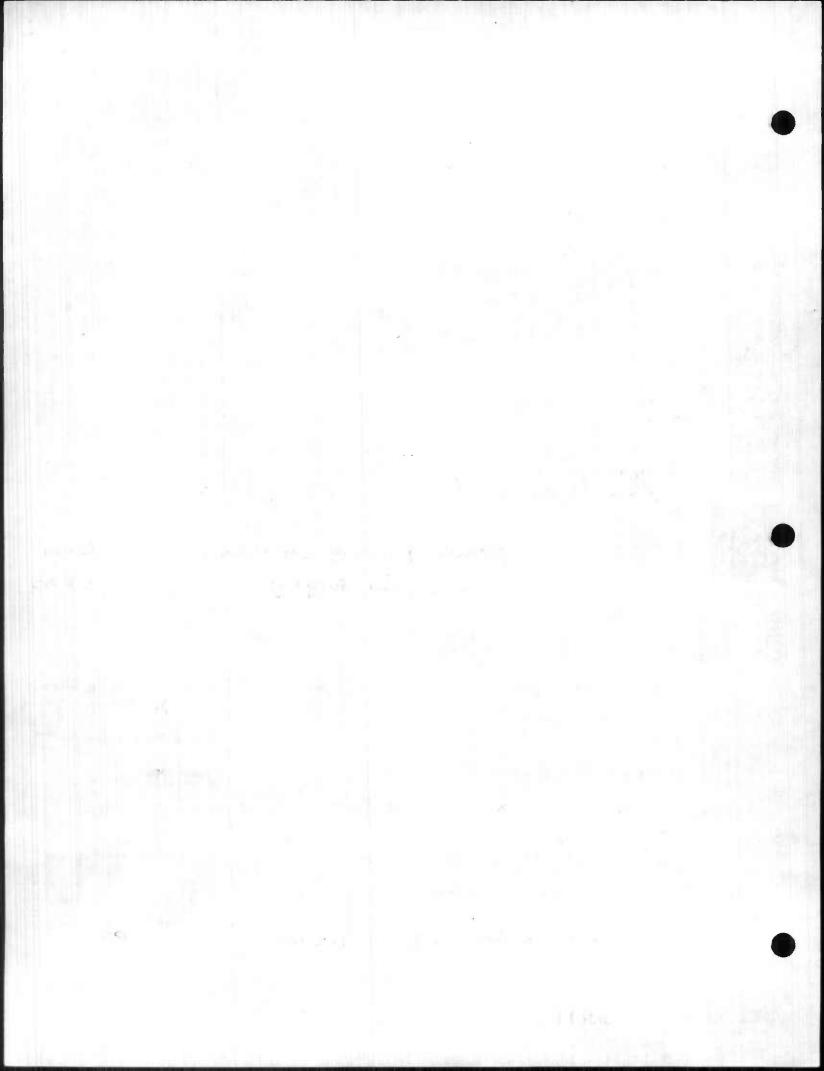
mD

State Registrar

5 Pending Investigation

6 Could not be determined

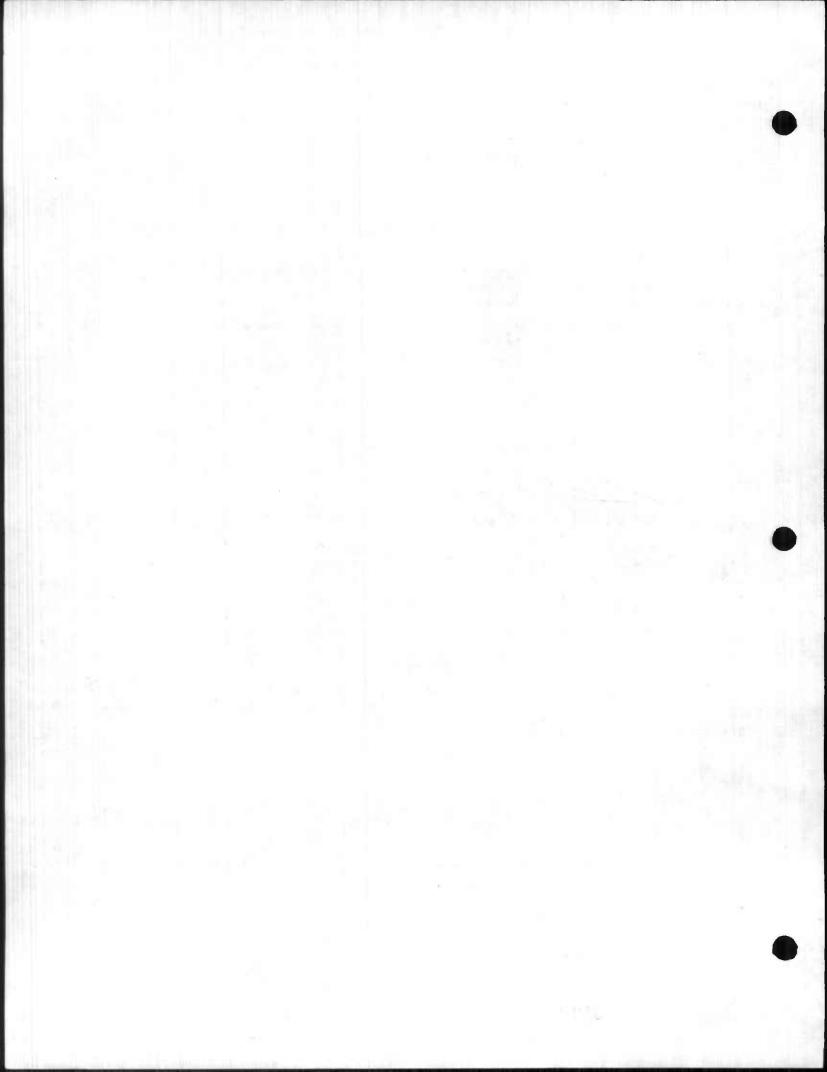




Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

| | | | State of Marylan | d / Departme Certific | ent of Health ate of Deat | n and Mental Hy th | rgiene () (| 02324 |
|----------------------------|---|--|--|--|---|--|------------------------------------|--|
| | | 1. Decedent's Name (First, Middle, Las | 0 | | | 2. Date of D | eath | 3. Time of Death |
| | Physician | DENNI | S MU | LLEN | | Month Jan | . 09 2 | 000 11:30AM |
| | /Medical Examiner | 4a Facility Name (If not institution, give | | | 4b. City, | Town, or Location of Deal | | |
| | Examine | Howard County | General Hospi | tal . | Colu | umbia | Howa | rd |
| _ | Funeral | 5. Social Security Number 6. Se | 7. Age (In yrs. I | last birthday) If Un | der 1 Year If Und | der 24 Hrs. 8. Date of Bi | | 9. Birthplace (State or Foreign |
| | Director | 239-07-8781 | XM 2□ F 8 | 36 Yrs. Mont | ns Days Hour | Jan. 8 | , 1914 | N.C. |
| | 2 . | Usual Residence of Decedent | I a au | | | | | |
| | show at at | 10a. State 10b. County | 10c. Cit) | , Town or Location | | | | 10d. Inside City Limits 1 ☐ Yes 2 🔀 No |
| | or 2844 about the Ma | Delaware Sussex |] 0 | reenwood | | | | |
| | Die Be | 10e. Street end Number | | | Zip Code | | 10g. Citizen of V | What Country? |
| | era la | RD. 1 Box 154-1 | | | 9950 | | USA | |
| Maryland 21215-0020 | 72 hours after death with the Marylas natural; or items 23a or 23a-f show that Examiner must be notified at sted by Furneral Director | 11. Marital Status 1 Never Merried 2 Married 3 Widowed 4 Divorced | 12. Was Decedent Ever in U, Armed Forces? 1 ☐ Yes AXNo If Yes, Give Year or Dates: | | pecify Cuban, Mexi | Origin? (Specify Yes or Nican, Puerto Rican, etc.) | | e - American Indien, kk, White, etc. |
| 9 | ted ted | 15. Decedent's Edu | ication | 16a. Decedent's U | sual Occupation | | 16b. Kind of Bu | usiness/Industry |
| 21 | ed within 72 ho yglene. we then "neturn it, the Medical. Completed | (Specify only highest grad Elementary/Secondary (0-12) | College (1-4or 5+) | (Give kind of life. DO NO | work done during m T use retired) | nost of working | | |
| 2 | A STATE OF | 8th | | Mainte | nance | | Tyler | Refrigeration |
| 믿 | Be went | 17. Father's Name (First, Middle, Last) | | | 18. Mo | other's Name (First, Middle | a, Maiden Sumam | ne) |
| yla | To He | Dirvise Mullen | | | L M | Issouri McMu | rren | |
| lar | de a de | 19a. Informant's Name/Relationship (T) | ype, Print) | 19b. Mailing Addr | ess (Street and Nur | mber or Rural Route Numb | ber, City or Town, | State, Zip Code) |
| | and | Deborah Thomas, | Daughter | RD. 1 B | ox 154-1, | Greenwood, | | |
| ore | Pages 1 hent of H int: If he iry or off | 20a. Method of Disposition 1 I Burial 2 ☐ Cremetion 3 ☐ F | | lace of Disposition (I | Name of or other place) | Dete | 20c. Location - | City or Town, State |
| Baltimore, | | 4 Donation 5 Other (Specify) | | dd Fellow | S | 1/15/00 | Milford | , De. |
| 3a | epartition in high in | 21. Signature of Funerel Save Licens | 00 | | and Address of Fa | | | |
| ш. | 20288 | 1// | | P.0 | . Box 168 | Funeral Hon 37, Easton, I | Maruland | 21601 |
| | Physician /Medical Examiner | 23a. Part1. Enter the disease, or comp shock, or heart feiture. List only of Immediate Cause (Final disease or condition resulting in death) | | Eumo | | es cardiac or respiratory a | arrest, | Approximate Interval Between Onset and Death |
| | - L | | Due to (or | r as a consequence | of): | | | Engli |
| | an and tel-transit Examiner | | b | | | | | 5 DAYS |
| , | es that the death certificate be executed igned by the ettending physician and be deteched for use as the buriel-transit by Physician/Medical Examir | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | Due to (or | as a consequence of | Of): | | | |
| 8760, | e bur | Cause (Disease or injury that initiated events | C. Due to /or | as a consequence of | vn. | | | |
| 68 | g ph the state | resulting in death) Last | 200 10 (01 | as a consequence c | n). | | | |
| Box | n cent | | d | | | | | |
| <u> </u> | the death certific by the ettending printed for use as inteched for use as Physician/Mec | Part II. Other significant conditions co | ntributing to death but not resu | ilting in the underlyin | g cause given in Pe | ort I. 23b. Did | tobacco uee coi | ntribute to the cause of death? |
| P.0 | ed by the detached | | | | | 10 | Yas 2□ No | 3 Probably 4 12 Unknown |
| | es the igned be de | | | | | | | , |
| ord | been sign should be leted by | | | | | 24a. Was | s an autopsy ormed? | 24b. Were autopsy findings available prior to |
| 00 | N 28 0 | | | | | | | completion of cause of death? |
| Œ | The lay | | | | | 10 | Yes 200No | 1 ☐ Yes 2 ☐ No |
| ta | ysicien: The is cartificete he director, pege To Be Corm | 25. Was case referred to medical axaminer? | | | 26. Pi | ace of Death (Check only | one) | |
| 2 | Physicien: r this cartific eral director, n: To Be (| 1 ☐ Yes 2 ☑ No | Hospital: 1 ☑ Inpatient 2 ☐ I | ER/Outpatient 3 | DOA Other: 4 | Nursing Home 5 ☐ Res | idence 6 Oth | er (Specify) |
| 0 | ng Pt ther th ners non: | 27. Manner of Death 1 ⊠Natural 5 ☐ Pending | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe | how injury occur | red |
| 0 | Attending or death. ector: After by the fune iffication | 2 Accident investigation | | М | 1 Yes 2 | □No | | |
| Division of Vital Records, | tal or Attending P rs after death. al Director: After t led in by the funers Certification: | 3 Suicide 6 Could not be determined | 28e. Place of Injury - At ho building, etc. (Specify | me, farm, street, fac | lory, office | | (Street and Numb wn, State) | er or Rural Route Number, |
| | O G C C C C C C C C C C C C C C C C C C | | | | | | | |
| | n 24 hound no 24 hound no Funer pletely fill | (Check only 2 Medical Exami | sician: To the best of my know ner: On the basis of examinati | vledge, death occurr ion and/or investigati | ed at the time, date lon, in my opinion, d | and place, and due to the leath occurred at the time, | cause(s) and ma date end place, | nner as stated. and due to the cause(s) |
| | To the Hospital or Attending Physician 24 hours after death. To the Funeral Director: After this completely filled in by the funeral Medical Certification: 1 | 29b. Signature and title of certifier | and manner stated. | | 29c. License numbe | | | |
| | F \$ P 8 | Signature and interest contined | NO: 10. | | 7 | 7 7 7 | | d (Month, Day, Year) |
| | | mean | / . | an M.D. | 143 | >49 | 2911 | . 09,2000 |
| | | 30. Name and address of person who or | 94 Hickor | y Ridg. | ABEDI E ROC | A ALINA | SHAN bia M | · 09,2000 D 21044 |
| | State Registrar | 31. Date filed (Month, Day, Year) | 32. Registrar's/Signat | ure B. | Ann 4 | 61 | | |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | | Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician Thelma L. Mills January 7, 7:57 a.m. /Medical 4c. County of Death Prince George's 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner District Heights 1752 Addison Road South If Under 1 Year | Months | Days if Under 24 Hrs. Hours Min. 8. Data of Birth (Month, Dey, Year)
November 28, 1935 Washington, D.C. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 F 64 Yrs. 054-30-7499 Director Usual Residence of Decedent the Maryland 10s. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show r than "natural", or hams 23a or 28a-f shorted at District Heights Prince George's Mary land YXYes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 20747 U.S.A. 1752 Addison Road SOuth permit. Pages 1 and 2 should be filed within 72 hours after deeth v
Department of Health and Meniel Hygiene.
Important: if item 27 is marked other than "natural", or items 23a
any Injury or other traumatic avent, the Medical Funeral Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married **Black** 21215-0020 1 Yes 2 No Specify P 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12th grade College (1-4or 5+) Account Technician Baitimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Mary Miller Willie Bailey 19a. Informant's Name/Relationship (Type, Print)
Mrs. Angela C. Fenwick (Daughter) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6014 Bryansview Way Bryans Road, Maryland 20616 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 Deurial 2 Cremation 3 Removal from State National Harmony Memorial Park 1/12/2000 Landover, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Corumbia registry Funeral Home 3605 14th St. N.W. Washington, D.C. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** lewdays /Medical Immediata Cause (Final disease or condition resulting in death) Examiner Examiner aranoma. or Attending Physician: The law requires that the death certificate be assouted Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last pue Due to (or as a consequence of): P.O. Box 68760. Physician/Medical 9 Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? Unknown been signed by ahould be detac 1 Yes 2 No 3 Probably Records, by 24b. Ware autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? this certificate has 1 Yes 2 No 1 ☐ Yes 2 ☒ No Division of Vitai funeral director, 8 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 A Residence 8 Other (Specify) Medical Certification: To 1 Yes 2 No 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1)ONatural after death.

Director: Aft
d in by the fur 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di completaly filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only 29d. Data signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number moule D 42580. MM 01-12-2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print), Ruth 13 BLAD GALI BURLI MD 20710.

State Registrar

31. Data filed (Month, Day, Year) JAN 1 4 2000

AUJLA MD

32. Registrar's Signatura

DHMH 16 Rev 6/95

COLUMN STREET

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 0 2326

| ician | 1. Dece | dent's Name (First, Mic | | 1.431 | | | | | | | 2. Date of Month | | Day | Year | 3. Time of Dea |
|--|--|--|--|---|--|--|---|---|--|-----------------|--|---|---|--|--|
| dical | | | rankl | | | onald | | | | | JANUAI | - | | 2000 | 1:21 P. |
| niner | 4a Feci | lity Neme (If not institu | tion, give s | treet and numbe | r) | | | 4 | b. City, To | wn, or L | ocation of De | eth | 4c. Count | - 11 | |
| | | COLM GROW N | | | ER | | | | AMP S | | | | | | ORGE'S |
| al | | I Security Number | 6. Sex | M 2 F 8 | lge (In yrs. | last birthday) | If Unde Months | Days | If Under Hours | 24 Hrs. Min. | 8. Date of (Month, March | Birth Day, Y | (ear) | 9. Birthe | place (State or For |
| r | | 09-5296 | 150 | 16 201 0 | <u> </u> | Yrs. | | | | | March | 5, | 1919 | Vir | ginia |
| | 10a. Sta | esidence of Decedent | ntv | | 10c. Cit | ty, Town or Lo | cation | | | - | | | | 11 | IOd. fnside City Lir |
| 6 | Mary | land Princ | | orge's | | xon Hi | | | | | | | | | 1 Yes 2 |
| Directo | | eet and Number | | | | | 101.7 | p Code | - | - | | 100 | . Citizen of | What Cour | ntn/2 |
| 1000 | 100. 30 | | | D | | | 101. 21 | - | E | | | 105 | | | ntry r |
| Funeral | 44 140-2 | 24 Mel | | 2. Was Deceder | t Ever in I | 6 12 1 | Was Door | 2074 | | lain? (Sn | ecity Ves or | No. | U.S | | can Indian, |
| ,5 | | Never Married 20XM | | Armed Forces | :7 | 2_ | If Yes, spe | city Cuba | n, Mexica | n, Puerto | ecify Yes or Rican, etc.) | | | ck, White, | |
| by | | Widowed 4 Divorce | | 1 XYes 2 In Yes, Give Year or Detes | 196 | 2 | 1 ☐ Yes | 2 Q₹No | Specify. | | | | Specia | fy: | White |
| | | | ent's Educ | | . 100 | 16a Decer | dent's Usa | at Occup | ation | | | 16 | 6b. Kind of E | Susiness/in | dustry |
| Completed | | (Specify only hig | hest grade | completed) | | (Give | kind of w | ork done d | during mos | t of work | ing Maint | | | | |
| E | Eleme | entary/Secondery (0-12 . 2 | | College (1-4o | r 5+) | Major | | | | ance Offic | | ena | U.S. | Armv | Ret. |
| | 17. Fath | er's Name (First, Midd | | | 62.0 | 124,02 | | | | | e (First, Mide | | | | |
| o Be | Be | ernard Fra | nklir | n McDon | ald | | | | | Hele | en | | Mowb | ray | |
| F | | ormant's Name/Relatio | | | | 19b. Mailir | ng Addres | s (Street | and Numb | 7 | al Route Nu | n <i>ber</i> , (| | | Code) |
| | 1 | nces J. Mo | | |) | | | | | | n Hill | | | | |
| | | thod of Disposition | | | | Ptace of Dispo | | | | | 4,2000 | | Oc. Location | | |
| | | Buriel 2 Cremation | | emoval from Stat | | lingto | | | | | • | | Arlin | aton | Virginia |
| | | Donation 5 Uther | | . / | AL | _ | | | | | ee Fun | _1 | | | - |
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DHMH 16 Rev 6/95

SAM 1 3 2000 Same of March ,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Miller **Physician** 000 2/2m /Medical Escility Neme (If not institution, give street and number) 4b, City, Town, or Location of Deeth Examiner ities Kiverdole George Md If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Dey, 5 Social Security Number 7. Age (In yrs. lest birthdey) 9. Birthplece (State or Foreign **Funeral** 1 M 2 □ F Months 249-36-1375 1924 Clinton, S.C. 75 Director Yrs. 29, Usuel Residence of Decedent 10e State 10b. County 10c. City, Town or Location Peges 1 end 2 should be filed within 72 hours after deeth with the Marylen nent of Health end Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23s or 28s-f show ury or other traumatic event, tra Megical Examiner must be notified as 10d. Inside City Limits 1 Yes 2 No Director P.G. Forestville 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 2917 Parkland, Drive Funeral 20747 U.S.A. 14. Race - American Indien, Bleck, White, etc. 12. Wes Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give A Yeer or Dates: Wes Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 1 Never Married 2f Married 21215-0020 1 ☐ Yes 2 ☐ No þ Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) Tractor Trailer Driver Trucking Baltimore, Maryland 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Melden Sumeme) Be Colvin Miller Lila Miller 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Annie P. Miller/ Wife 2917 Parkland, Drive, Forestville, Md. 20747 20b. Plece of Disposition (Neme of cemetery, cremetory or other piece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 ☐ Cremetion 3 ☐ Removel from Stete permit. Pege Department of Important: If any injury or once. Washington Nat Cem 1/15/00 Suitland, Md. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funerel Service Licensee 22. Neme end Address of Fecility Johnson & Jenkins Inc. 716 Kennedy St., N.W. Wash. D.C. 20011 23e. Pert1. Enter the disease, or demplications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Intervel Between Onset end Deeth Physician /Medical Immediate Cause (Final namous diseese or condition resulting in deeth) Examiner Physician/Medical Examiner The lew requires that the death certificate be executed the buriel-transit Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Last Due to (or es e consequence of). P.O. Box 68760, Due to (or es e consequence of): Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco uss contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No Division of Vital Records, þ 99 24b. Were eutopsy findings evelleble prior to completion of cause of death? Be Completed 24e. Wes en eutopsy performed? 1 Yes 2 No this certificate or Attanding Physician: 25. Wes case referred to medical exeminer? 26. Place of Deeth (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpetlent 3 ☐ DOA 28a. Dete of Injury (Month, Day Year) 27. Menner of Deeth 28d. Describe how Injury occurred 28b. Time of 28c. Injury st Work? After 5 Pending Investigation Nature s after deeth. 1 ☐ Yes 2 ☐ No 2 Accident 3 Sulcide 6 Could not be 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) filled in by 4 Homicide To the Hospital o within 24 hours af To the Funeral Di 29a. Certifier Certifying Physicien: To the best of my knowledge, deeth occurred et the time, date end place, and due to the ceuse(s) end menner es steted.

[In Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the ceuse(s) end menner steted. Medical completely (Check only one) 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) M.D D48213 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) RD M. ALHAI Mitchillulle #220 Bowne 4000

State Registrar 31. Dete filed (Month, Dey, Year) JAN 1 2 2000

32. Registrer's Signeture

Piet.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** PERCY EDWARD McLEAN JR. JANUARY 8,2000 12:45am /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Death Examiner MARINER HEALTH OF SOUTHERN MARYLAND CLINTON PRINCE GEORGES If Under 24 Hrs. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplace (Stata or Foreign Country) **Funeral** Days Hours MM 20F 240-54-6925 MARCH 23,1938 Director DUNN, NC 61 Usual Residence of Decedent 6 1/5 10b. County 10c. City, Town or Location 10d. Inside City Limits na 23a or 28a-f abor MD PRINCE GEORGES 1 Yes 2 No DISTRICT HEIGHTS Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7103 HALLECK ST. 20747 UNITED STATES Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2XXVo If Yes, Give Yeer or Detes: Hema 14. Rece - American Indian, Black, White, etc. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status filed within 72 hours after 1 Never Merried 2 Merried 8 21215-0020 1 ☐ Yes 2X No Specify: BLACK Specify: by 3 Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) SUPERVISOR OF D.C. HOUSING DC GOVT Maryland 17. Fathar's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumame) . Pages 1 and 2 should be fill iment of Health end Mentel Hant: If item 27 is marked out Be PERCY E. McLEAN JANIE SMALLS 19a. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stata, Zip Code) nt of Health e If item 27 is or other tra KAREN McLEAN / DAUGHTER 5335 DUKE ST #510, ALEXANDRIA, VA 22304 Baltimore, 20b. Plece of Disposition (Name of cematary, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ABurial 2 Cremetion 3 Removel from Stete pemit. Page Department of Important: If any Injury or CEDAR HILL CEMETERY 1-12-00 SUITLAND, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Sprvice Licensee 22. Name end Address of Facility S. POPE FUNERAL HOME 5538 MARLBORO PIKE, FORESTVILLE, MD 20747 or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, and only one cause on each line. Approximate Interval Between Onset and Deeth Physician /Medical Immediate Ceuse (Finel erere, mulmursh disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner arcmma The lew requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediata cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last pug Box 68760. metastass To Physician/Medical the Dua to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yes 2 No 3 Probably 4 Unknown Records, by ate hes been signe page 2 should be 24b. Were autopsy findings available prior to completion of cause of death? Be Completed Jeine disorders 24a. Was an autopsy performed? 25. Was case referred to medical axaminer? 1 ☐ Yes 2 No 1 Yes 2 No certificate Division of Vital or Attending Physician: 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 1 Yes 2 No this 28a. Dete of Injury (Month, Day Year) 27. Menner of Deeth 28b. Time of 28c. Injury at Work? 28d. Dascribe how injury occurred After 1 Netural 5 Pending Hospital or Attending 24 hours after deeth.
 Funeral Director: After 1 Yas 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Piece of Injury - At homa, term, street, factory, office building, etc. (Specify) 28t. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide 150 Certifying Physician: To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and menner stated. 29e. Certifier (Check only one) within 2 **a** 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 0 01-11-2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BAHRAM PISHDAD, M.D. 1328 SOUTHERN AVE S.E. # 310 WASHINGTON DC 20032 32, Registrar'a Signeture 31. Dete tiled (Month, Dey, Year) State

DHMH 16 Rav 6/95

Registrar

JAN 1 2 2000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 2 3 2 9

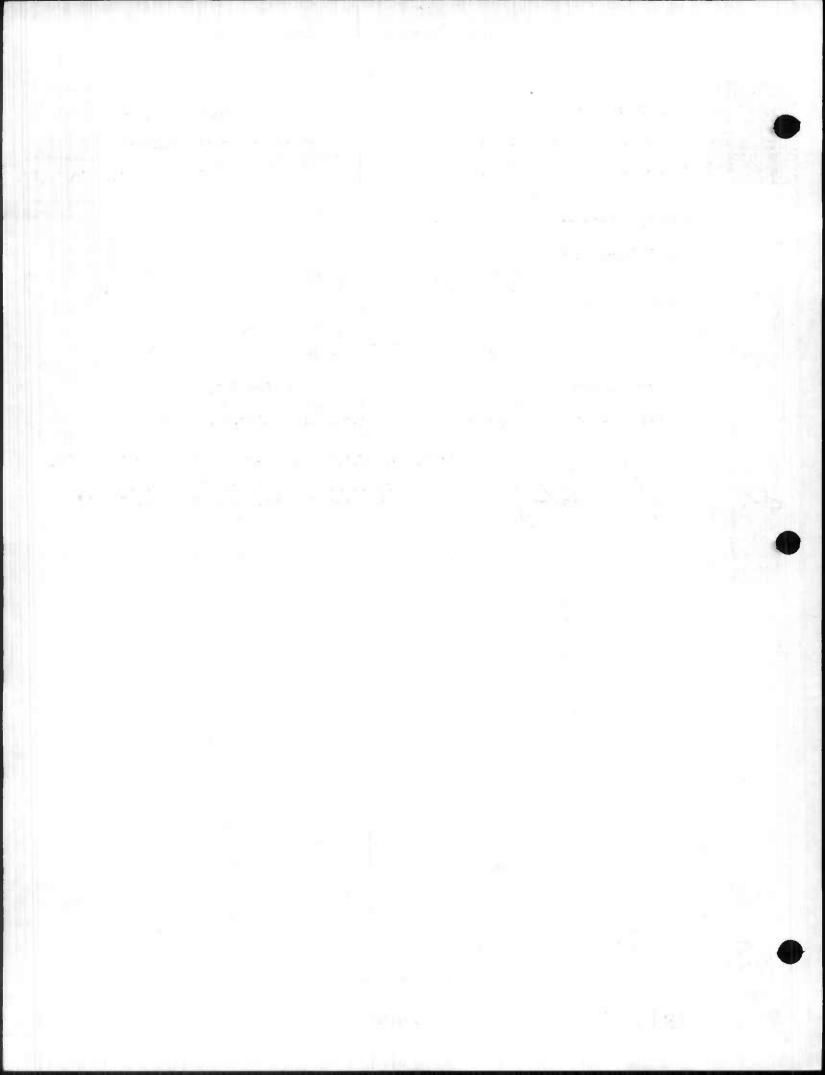
Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Α. VIRGINIA MCGRATH 4b. City, Town, or Location of Deeth 4c. County of Death /Medicai 21:55 4a. Facility Neme (If not Institution, give street and number) Examiner Calvert Memorial Hospital Prince Frederick Calvert If Under 1 Year It Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1□M 2♥F 79 200-09-2940 Yes Director June 7,1920 Philadelphia, PA. Usuel Residence of Decedent the Merylend 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow 7 is marked other than "naturat", or itams 23a or 28a-f ahov traumatic event, the Medical Examinar must be notified as 1 Yes X No Director Maryland Calvert Dunkirk 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 3011 Jones Road 20754 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1951 10 X/ss 2 □ No If Yes, Give Year or Detes: 1t. Maritel Status Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Reca - American Indien, Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0020 bruil. Pages 1 and 2 should be filed within 72 hours aft Deportant: If Itam 27 le marked other than "naturat", or I any Injury or other traumatic event, it a World Emission and Injury or other traumatic event, it a World Emission and Itam. 1 Yes 2 No Specify: White by 3\ Widowed 4 Divorcad Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 5+ Elementery/Secondary (0-12) Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) Be Harry S. Pickel Mary Ann Smith 20 19e. Intormant's Name/Relationship (Type, Print) 19b. Malling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Kolleen I. McGrath/Daughter 3011 Jones Road Dunkirk, Md. 20754 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State t X Burial 2 Cremetion 3 Removel from State 4 Donation 5 Other (Specify) Arlington National Cemetery 1/19/2000 Arlington, VA. Funeral Service Licensee 22. Name end Address of Fecility George P. Kalas Funeral Home, P.A. 6160 Oxon Hill Rd. Oxon hill, Md. 20745 Past 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** /Medical immediata Cause (Final CHRONIC OBSTRUCTIVE PULMONARY DISEASE disease or condition resulting in death) Examiner Due to (or es a consequence ot): Physician/Medical Examiner ettending physician and for use as the burial-transit certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown 2 PNEUMONIA signed be del Records, þ 24b. Were autopsy tindings available prior to completion of ceuse of death? Completed 24a. Was an autopsy performed? page 2 s certificate 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p Be 25. Was case reterred to medical examiner? 26. Place of Death (Check only one) Hospital: 1□ Yes 2☑ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Dete of Injury (Month, Dev Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 1 Naturat 2 Accident 5 Pending investigation 1 Yes 2 No 3 Suicide 6 Could not be determined Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, tarm, street, factory, office building, etc. (Specify) 4 THomicide Medicai 29a, Certifier 1 Certifying Phyalctan: To the best of my knowledge, death occurred at the time, date and piace, and due to the ceuse(s) end manner as stated.
2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and piace, and due to the ceuse(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D40370 00 30. Name and address of person who completed ceuse of death (item 23a) (Type, Print) Dr. Peter Wisniewski, M.D. Prince Frederick, MD 20678 31. Date filed (Month, Day, Yeer) 32. Registrar's Signeture State

DHMH 16 Rev 6/95

Registrar

2000

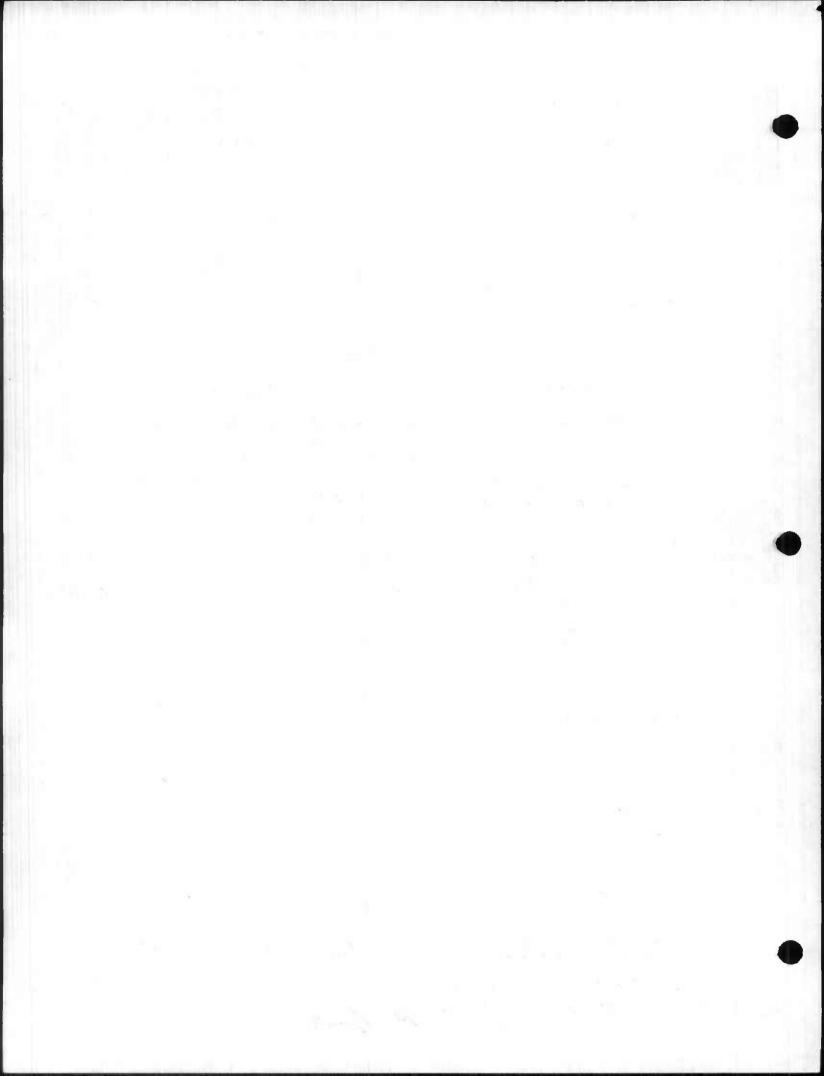


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 0 2 3 3 0

| -1 | | 10.10 | | | Certificate o | f Death | Re | g. No. | | |
|--|------------------|--|--|----------------------|--|---|---|------------------|--|--|
| Physi /Med | | 1. Decedent's Name (First, Middle, La Mary Louise | | | | | 2. Date of Death Month Jan 8 | Day | Year 3. Time of Death 5:30 pm | |
| Exam | | 4a. Facility Name (If not institution, given | e street end number) | | | 4b. City, Town, or L | | 4c. County | - | |
| | Ţ., | Carroll County G | | spital | | Westmi | | - | rroll | |
| Funera Directo | | 215-82-1502 | Sex 7. Ag 1 □ M 2 ☑ F | a (In yrs. last bi | Yrs. If Undar 1 Yas Months Day | | 8. Date of Birth (Month, Day, Aug 14, | 191 5 | Birthplace (State or Foreign Country) Maryland | |
| dand dand | | Usual Residence of Decedant 10a. State 10b. County | | 10c. City, Tov | wn or Location | | | | 10d. Inside City Limits | |
| he Mary 28a-f sh offited | ector | Maryland Carr | oll | | | Hampstea | - | | 1 □ Yas 2 ☒ No | |
| 23a or 3 | Funeral Director | 10e. Street and Number 414 Lees Mill R | load | | 10f. Zip Code | 2107 | | 0g. Citizen of W | /hat Country? USA | |
| DESILLINOYE, MISTYISING Z1Z13-UUZU permit. Peges 1 end 2 should be filed within 72 hours effer death with the Maryland Department of Heelth and Mentel Hygiene. Important: If item 27 is marked other than "natural", or itema 23e or 28e-f show any injury or other traumatic event, the Medical Examinet must be notified at | þ | 11. Marital Status 1 Nevar Married 2 Married 3XX Widowed 4 Divorced | 12. Was Decedent Armed Forcas? 1 Yes 2 1 if Yes, Give Year or Dates: | | 13. Was Decedent of If Yes, specify Co | f Hispanic Origin? (Spuban, Mexicen, Puarto Specify: | pecify Yas or No- Rican, etc.) | | e-American Indian, k, White, etc. White | |
| aryliand 21215-UUZU should be filed within 72 hours et nd Mentel Hygiene. i marked other than "netural", or umatic event, the Modical Exert | Completed | 15. Decedent's E (Specify only highest gra Elemantary/Secondary (0-12) | | | n. Decedant's Usual Occ (Give kind of work dor life. DO NOT use reti Houses | ne during most of work ired) | king | | siness/industry Home | |
| ACT YICHO 212 2 should be filed within and Mentel Hygiene. Is marked other than reumatic event, me Mentel than the Mentel than | Be Co | 17. Father's Name (First, Middle, Last |) | | | 18. Mothar's Nam | e (First, Middla, N | faiden Surnem | 9) | |
| ylan | 70 | Joshua Grant Del | | | | Ida Ma | y Allgir | е | | |
| Mal Shand 2 shand 2 shand 27 is m | | 19a. Informant's Name/Relationship (James Mann, son | Type, Print) | 19 | b. Mailing Address (Stre 3319 August | | | | | |
| is 1 and 2 of Health (frem 27 is | | 20a. Method of Disposition | | 20b. Place o | of Disposition (Neme of ery, cremetory or other p | | | | City or Town, State | |
| Peges nent of I | | 1 ABurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special | | | ley Cemeter | | 1/12 | Hamp | stead, MD | |
| Dattimore, Maryland permit. Peges 1 end 2 should be file Department of Heelth and Mentel Hy Important: If item 27 is marked othe any injury or other traumatic event. | BOILGE | 21. Signature of Funeral Sarvice Licer | W MOO | 1723 | 22. Name and Add | outh Main | | Funera stead, | | |
| Physiciar /Medica | | 23a. Part1. Enter tha disease, or com shock, or heart failura. List only Immediate Cause (Final | | | | | or respiratory arre | st, | Approximate Interval Between Onset and Death | |
| Examine | | disease or condition rasulting in death) | a. TUTIYIO | Due to (or as a | Embolus |) | | | days | |
| pe list | Medical Examiner | | b. Atria | 1 Fib | rillation | | | | months | |
| tificete be executed ag physicien end es the bunel-transit | Exa | Sequentially list conditions, if any, leading to immediata ceuse. Enter Underlying Cause (Disaasa or Injury | | Dua to (or as a | consequence of): | | | | | |
| ficete be ex physicien s the buriel | dlcai | Cause (Disaasa or Injury that Initiated events resulting in death) Last | C | Due to (or as a | consequence of): | | | | | |
| ath certific attending p | /Me | L | d | | | | | | | |
| death death death | Physician/N | Part II. Other significant conditions of | ontributing to death bu | ut not resulting | In the underlying cause | given In Pert I | 23b. Did tol | hacco use con | tributa to the cause of death? | |
| that the de ned by the | by Phys | Meningioma | | | | | 1□ Ye | | 3 Probably 4 Unknown | |
| The Colds, F.C. Box corou, The law requires that the death certificate be executed the hes been signed by the ettending physician and page 2 should be detected for use as the buriel-transit | Completed b | | | | | | 24a. Was an | autopsy ned? | 24b. Were autopsy findings available prior to completion of causa of death? | |
| Physician: The law riths certificate hes | Com | | | | | | 1□ Ye | s 200 No | 1 Yas 2 No | |
| clan: entific ector, | Be | 25. Was case referred to medical examiner? | 11 | | | | th (Check only one | 9) | | |
| hysic of this of all directions | 2 | 1 Yes 2 No | Hospital: | | utpatient 30 DOA | | me 5 Reside | - | | |
| or Attending Physician: Tefar death. Director: After this certifical in by the funeral director, p | Certification: | 27. Manner of Daath 1 ☑ Natural 5 ☐ Panding 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not b | | Year) | | ☐ Yes 2 ☐ No | 28d. Describe ho | w Injury occurre | ed | |
| tal or Att | Certifi | 28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office City or Town, Stete) | | | | | | | | |
| To the Hospital or Attending F within 24 hours efter death. To the Funeral Director: After completely filled in by the funer | edicai | | | | | | | | | |
| To the To the Company | 2 | 29b. Signatura and title of certifier | Δ Δ | | 29c. Lice | nse number | | | (Month, Dey, Year) | |
| | | Herlit K. He | ndr/ | m | 00 | 1051924 | C | 1-08 | -00 | |
| | | 30. Name and addrass of person who Herbert P. Hen de | completed ceuse of the | eath (item 23a) M () | (Type, Print) 295 Stor | ner Ave S | juite30 | 7 We | stminster, MD | |
| S | tate | 31. Data filed (Month, Dey, Yaar) | 32. Registra | ar's Signature | 6 1 | | | | | |

DHMH 16 Rev 6/95



Please Type or Print in Biack Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene \ Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Blake** 0swell Moore. Jr. 7:03 AM JAUARY 4a Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Doctors Community Hospital Lanham Prince Georges If Under 24 Hrs. 6. Sex 1 M 2 □ F If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthdey) 8. Dete of Birth (Month, Day, Year) 1945 9. Birthplace (Stete or Foreign Country) 54 578-56-8894 February 20, Washington, D.C Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No Maryland Prince Georges Glen Dale 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? Armed Forces? Feb.19 64 If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 13. Wes Decedent of Hispanic Origin? (Specify Yes or No16 Yes, Sive Yes, Give Yes or Detes: Aug. 1970 9922 Martin Avenue United States 12. Wes Decedent Ever in U.S. Armed Forces? 14. Rece - American Indian, Bleck, White, etc. 11 Marital Status 1 Never Married 2 Merried Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Washington Convention Elementery/Secondery (0-12) College (1-4or 5+) 2 years Center Electrician 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Blake Oswell Wilhelmina Williams Moore, Sr. 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informant's Neme/Reletionship (Type, Print) Pamela Marie Butler Moore (wife) 9922 Martin Avenue; Glen Dale, Maryland 20769 20b. Plece of Disposition (Name of cametery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stata Jan. 12, 2000 1X Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Maryland Veterans Cemetery Cheltenham, Maryland 22. Name and Address of Facility Robert G. Mason Funeral Home, Inc. sture of Fuseral Service License 1661 Good Hope Road, S.E.; Washington, DC. 20020 23a Par 7. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, not heart failure. List only one cause on each line. Approximete Intervel Between Onset end Death Immediete Ceuse (Finel disease or condition resulting in deeth) ACUTE CEREBRAL HEMMRHAGE ERTENSION Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown

Physician /Medical Examiner

and

physician s the buriel

signed be de

Box 68760

P.O.

Records,

Division of Vital

Mospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this certifica

3

filled

teh

within 2 within 2 complet

mportant: If item 27 is my injury or other trau

Physician

/Medical

Examiner

Directo

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20

Funeral

Director

'natural', or itsms 23s or

Examiner Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initieled events resulting In death) Last

Physician/Medical Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 24b. Wera autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Be Completed 1□ Yes 20 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 R/Outpatient 3 DOA 27. Menner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Netural 5 Pending 1 ☐ Yes 2 ☐ No investigetion 2 Accident 3 ☐ Suicide 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, lectory, office building, etc. (Specify) 4 Homicide 29e. Certifier Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and mannar as stated. Medical 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

29b. Signeture and title of certifier

29c. License number

Stewe Kunsu MD

29d. Dete signed (Month, Day, Year)

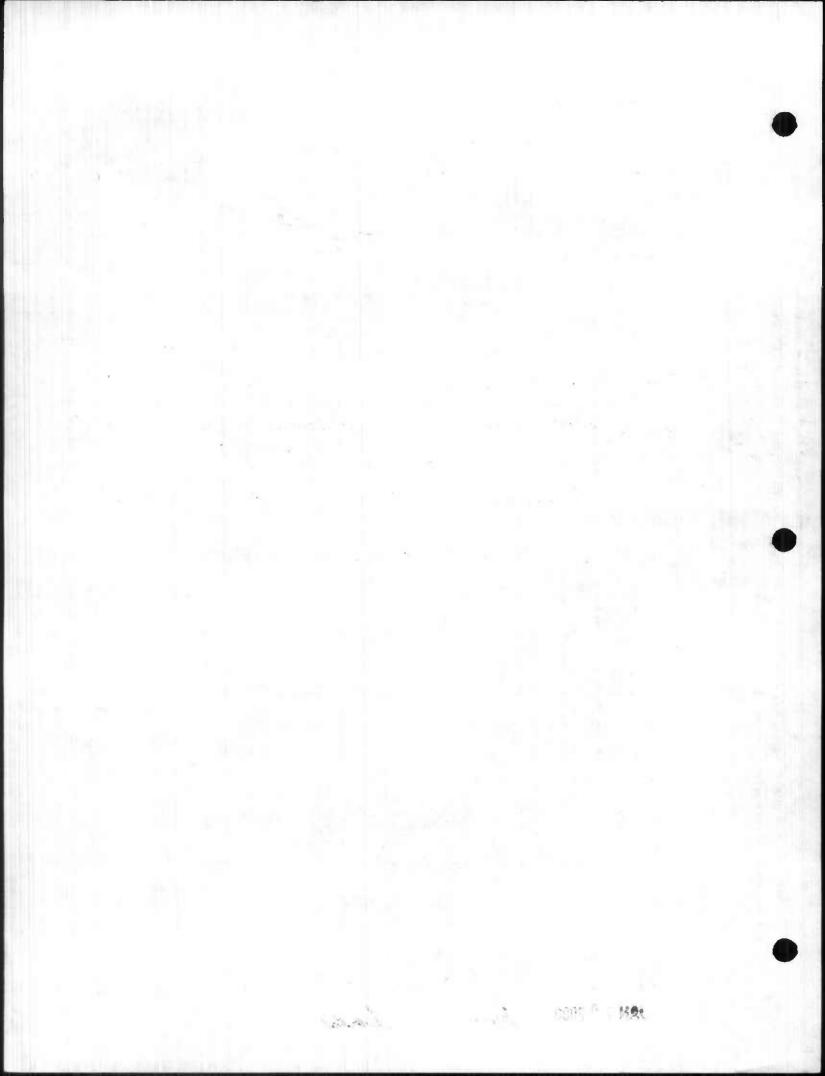
Va

State

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) SIB GOOD LUCK ROAD, LANHAM, MD 2070G

STEVEN REMOVEN, MD 31. Date filed (Month, Dey, Year)
JAN 1 0 2000

32. Registrer's Signeture



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 00002332

| | | | | | Certificate o | f Death | | Reg. No. | | |
|--|--|--|---|---------------------|--|---------------------|-------------------------------|------------------------|-----------------------|---|
| | | me (First, Middle, Li | nst) | | | | 2. Dete of De | ath | V | 3. Time of Death |
| Physician Medical | | NOI | RMAN A. | M | ARCERON, | JR. | JAN. | 7, ^{Day} 2000 | Year | 7:00 AM |
| Examiner | 4a Facility Name | (If not Institution, gi | ve street and number) | | | 4b. City, Town, o | or Location of Deat | 4c. County | of Death | |
| | 2837 R | IDGE RD | | | | WESTMI | | CARRO | | |
| Funeral | 5. Social Security | | Sex 7. Ag | e (In yrs. last bir | Months Day | | in. (Month, Da | th ly, Year) | 9. Birthple Countr | ace (State or Foreign |
| Director | 579-48 Usual Residence | -6511 | | 66 | Yrs. | | 6/9/1 | 933 | VASHI | NGTON, DO |
| and | 10a. State | 10b. County | | 10c. City, Town | n or Location | | | | 10 | od. inside City Limits |
| Wenyt | MD. | CARROI | LL | WESTM | INSTER | | | | | 1 ☐ Yes 2 ☑ No |
| Maryland 21215-0020 d 2 should be filed within 72 hours after death with the Meryland th and Mental Hygiene. T is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examiner must be notified at To Be Commissed by Figureal Director | 10e. Street and N | lumber | | | 10f. Zip Code | • | | 10g. Citizen of \ | What Countr | iny? |
| With with | 2027 D | IDGE RD. | | | 211 | - 7 | | TICA | | |
| of the death viter death viter death viter mail | 11. Maritel Status | | 12. Wes Decedent | Ever in U,S. | 13. Wes Decedent of if Yes, specify C | | (Specify Yes or No | USA . | e - America | |
| In the Part of the | 1 ☐ Never Ma | rried 2 Married | Armed Forces? | NOREA! | if Yes, specify C | | erto Rican, etc.) | | ck, White, e | itc. |
| 21215-0020 within 72 hours aft giene. The matural; or the matural; or the month of the foundation of t | 3 ☐ Widowed | 4 ☐ Divorced | If Yes, Give Yeer or Detes: | CONFLIC | 1□Yes 2X0N | lo Specify: | | Specity | WHI | ITE |
| 1 21215-002 led within 72 hours a ygiene. ygiene "neturel", o rt, ire Medical Exat Completed by | (Sn | 15. Decedent's E | ducation | 16a. | Decedent's Usual Occ | cupation | vodkina | 16b. Kind of B | usiness/Indu | ustry |
| within within then then then then then then then the | Elementery/Se | condery (0-12) | College (1-4or 5 | i+) | (Give kind of work dor life. DO NOT use ret | ioning | | | | |
| Noise of S | | 12 | 6 | | TEA | CHER | | EDUCA | | |
| Do doth Hall H | 17. Father's Nem | e (First, Middle, Las | | CERON | CD | | lame (First, Middle, | | | |
| should and Men marke | • | | N A. MAR | | | CATHA | | OETZIN | | |
| Maryland d 2 should be file th and Mental Hy the American | | Name/Reiatlonship | | | . Malling Address (Stre | | | | | |
| CENL | | E MARCER | ON - WI | | B37 RIDGE Disposition (Name of | RD., WE | | | | |
| 0 90 - 2 | 20a. Method of D | • | ☐Removal from Stete | cemete | ry, crematory or other p | | Dete | 20c. Location - | | |
| timent tant: Hag | | 5 Other (Speci | | METRO | CREMATO | | /8/2000 | | | , |
| Baltimore, pemit. Pages 1 ar popartment of Hear important: If Nem 3 any injury or other once. | 21. Signeture of | Funeral Service Lice | nsee | | | | LETCHER | | | |
| 20260 | H | omas). 7 | lotel 1 | • | 234 E. | MAIN SI | .,WESTM | TNOIEK | , PID. | . 21137 |
| | 23a. Part1. Enter shock, or he | r the disease, or consart failure. List only | pications that caused one cause on each li | the death. Do i | not enter the mode of o | lying, such as card | liac or respiratory a | rrest, | | Approximete Interval Between |
| Physician | | | | | | | | | i i | Onset and Death |
| /Medical Examiner | Immediate Cause disease or condit resulting in deeth | tion | a. Me | ta sta | to pro. | state | CAHCE | - | | 11/4 xr. |
| CONTRACT CONTRACT | | , | | Due to (or as e | consequence of): | | | | | |
| 68760, iteate be executed physician and sthe burial-transit edical Examination | | | b | | | | | | 1 | |
| \$8760, cate be executed physician and sthe burial-transit | Sequentieily list of the life any, leading to | conditions, Immediate | | Due to (or as a | consequenca of): | | | | | |
| 60 be e | cause. Enter Un Cause (Disease | derlying or injury | c | | | | | | | |
| t 68760, rifficate be executed ng physician and s as the burial-transit | that initiated ever resulting in death |) Last | | Due to (or as e o | consequence of): | | | | | |
| | | | d | | | | | | | |
| Cords, P.O. Box v requires that the death cert been signed by the attending should be deteched for use letted by Physician/N | Bod it Other slee | Minna na na diatana | | | | alian in Dani I | 935 014 | tohooso was an | a talbusta sa | the same of death? |
| P.O. at the d by the leteched | Pert II. Other sign | | | ut not resulting it | the underlying cause | given in Part I. | | Yes 2 No | | the cause of death? |
| | | None | Khowh | | | | _ '' | TOS ZLYNO | 3 Prob | abiy 4 Onknow |
| Records, P.O. he law requires that the e hes been signed by the ege 2 should be deteche ompleted by Phys | | | | | | | | an autopsy | | re autopsy findings |
| Should should be | | | | | | | perfo | ormed? | com | Illable prior to npletion of cause death? |
| The law requirate has been spage 2 should | | | | | | | 10 | Yes 2 No | | Yes 2 No |
| (1 | | erred to medical | | | | 26 Place of F | Deeth (Check only | | | 1198 2 140 |
| Vision of Vita Attending Physician: Acteath. ector: After this certific by the funeral director, iffication: To Be (| | √No | Hospital: | ent 2 ER/Ou | stpatient 3 DOA | Other | Home 5 Resi | | er (Snecity | ,1 |
| Physical dispersion of Tr. Tr. | | ath | 28e. Date of Inju | ry. 28b. 1 | Fime of 28c. in | | | how injury occur | | , |
| ion offing th.: Afte | 1 ☑Natural 2 ☐ Accident | 5 Pending investigation | (Month, Da | y rear) | | Yes 2 No | | | | |
| Division or Attending after death. Director: After d in by the fune | 3 ☐ Suicide 4 ☐ Homicide | 6 Could not be determined | 289. Placa of Inj | | rm, street, factory, offic | 00 | 28f. Location (City or To | Street and Numb | ber or Rural | Route Number, |
| Division of the control of the contr | 4 Britishia | | bollonig, et | c. (Specify) | | | Ony or 10 | wii, State) | | |
| | | 12 Certifying Pl | hyaician: To the best | of my knowledge | , deeth occurred at the | time, date and pla | ica, and due to the | cause(s) and ma | anner as sta | ated. |
| he Hospin 24 hound he Funer pletely fill | | 2 Medicai Exa | and manner st | | d/or investigation, in m | y opinion, deeth oc | curred et the time, | date end piece, | and due to | the cause(s) |
| With To the Common Comm | 29b. Signeture er | d title of certifie | 1 4 | | 29c. Lice | ense number | 111 | 29d. Dete signe | d (Month, E | Day, Year) |
| | H | und | Danay. | m .D. | 91. | 5552 | (Md.) | 1/ | 1/0 | 6 |
| | 30. Name and ad | dress of person who | completed cause of d | | | ., | | | | |
| All markets and the | Howar | J Jaioz | 1+2 H.D. | 224 | Washinga | ton He | ights h | lastmin | ster, | md. 21157 |
| State | 31. Dete filed (Mo | onth, Day, Year) | 32. Regist | ar's Signature | 6 1 | | | | | |
| Registrar | | JAN 10 | 2000 | | 10. pp | als | | | | |



Please Type or Print in Black indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 2333

| | | | | | Ce | ertifica | ate of | Death | | Reg. No. | | |
|---|---|---|---------------------------------------|--------------------------------------|--|-------------|----------------------|--|---|-------------------|----------------------------|---|
| Dhuaisian | 111111111111111111111111111111111111111 | nt's Neme (First, Midd | 0.00 | | 2 | | | | 2. Date of Dea | ath Dev | Year | 3. Time of Death |
| Physician /Medical | | 1 A38 | T. | MA | 9 | | | | JAN4. | pay 7 c | 2000 | 3:15% |
| Examiner | | Neme (If not Institution | | | | | | | Location of Death | | _ | |
| | | 22 Hitchi | | | | | | | sville | Howa | ard | |
| Funeral Director | 231-1 | ecurity Number 12-5117 idenca of Decedent | 6. Sex 1 □ M 2 ▼ F | 7. Age (In yrs | . last birthday Yrs. | Month | ler 1 Year s Days | If Under 24 Hr. Hours Min | | 9,7991 | 9. Birthpl Count V1T | lace (Stete or Foreign fry) ginia |
| Pur Bu | 10a. Stete | | | 10c. C | ity, Town or L | ocation | | | | | 10 | Od. Inside City Limits |
| Many Fed field | MD | Hov | ward | 1 | Cl | arksv | ille | | | | | 1 ☐ Yes 2 🐼 No |
| th with the Maryla 23e or 28ef show at he notified at | 100.00 | and Number 22 Hitchi | ing Post | Court | | 10f. 2 | Zip Code 21 | 029 | | 10g. Citizen of V | | try? |
| er death frame 2: per mas | 11. Marital | | | edent Ever in U | | Was Dec | pedent of h | lispanic Origin? (en, Mexican, Pue | Specify Yes or No- into Rican, etc.) | 14. Rac Bied | e - America | |
| 21215-0020 4 within 72 hours after plane. r than "natural", or it its Medical Examin Completed by Fi | | ver Married 2 Mer dowed 4 Divorced | If You Gi | /0 | | | | Specify: | | 100 | whi | |
| 5-0-5-10 72 he hashing lightly | | | it'a Education st grade completed) | | 16a. Deci | edent's U | ual Occup | pation during most of we | orkina | 16b. Kind of Bu | usiness/Ind | lustry |
| 21215 ed within 72 yglene, er than 'na r, the Medis | Element | ery/Secondery (0-12) | College (| I-4or 5+) | 5+) life. DO NOT use retired) | | | | | Domos | -+ | |
| Co the state of | 3 | | 3 | 1 Homemaket | | | | | | Domes | | |
| De san a | 17. Father | a Name (First, Middle, | | le Mos | .1 | | | | eme (First, Middle, | , | | |
| yla Mound Mound To | | harles I | Frederic | k Tay | lor | | | Bell | | | airie | |
| ABT 2 Sth | | 19a. Informent's Ne <i>mer</i> /Reletionship (<i>Type, Print</i>) Mr. David S. May (Son) 19b. Meiling Address (Street end Number or Rural Route of 6722 Hitching Post Ct. | | | | | | | | | | |
| and | | Mr. David S. May (Son) 6722 Hitching Post Ct., Clarks | | | | | | | | | | |
| Pages 1 Pages 1 ment of Hi | 1 □ B | od of Disposition urial 2 KI Cremation onetion 5 □ Other (S | | State | Plece of Disp cametery, cre 11 Cou | emetory o | r other pla | | . 1/9/20 | 20c. Location - | | |
| Ball permit Depen Import any in | 21. Signat | Burneral Service | Licensee | lut. | 2 | | | uneral H | ome & Cha 21784 (4 | apel, PA | A (Bo) | x 195) |
| | 23a. Part1 | Enter the diseese, or k, or heert feilure. Liat | complications that | used the dea | th. Do not er | | | | | | -1400 | Approximate |
| Physician | shoc | K, or heert feilure. List | only one ceuse on | iech line. | | | | | | | | Intervel Between Onset and Deeth |
| /Medical | Immediate | Cause (Finel | 2 | 711 - | (, , , , | n | ~ ~ 6 | L. | | | | LIODEN |
| Examiner | disease or resulting Ir | | a | 4118 | NAUT | 17 | ern | ythur's | | | | 20000 |
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| oxec n an ial-tra | if any, leed | lly list conditions, ding to immediate ster Underlying seese or Injury | | Due to (| or as a conse | duence o | 1). | | | | | |
| 68760, ifficate be executed 9 physician and as the burial-transit | | ed events | c | Due to / | or as a conse | auanaa a | n. | | | | | |
| ophy as the | resulting in | death) Last | 201 | Due to (| or as a conse | dneuce o | 1). | | | | | |
| | | | d | | | | | | | | 1 | |
| beath cer attendir of for use | Bod II Oth | | nne contribution to d | anth hut mat an | nulting to the | | | on in Dart I | ass Did s | ohoooo waa oo | ntelburto to | the cause of death? |
| IS, P.O. BOX res that the death cert igned by the attending be detached for use. by Physician/M. | Pert II. Oth | er algnificant condific | ons contributing to o | eath out not re | sulting in the | underlying | cause gr | ven in Part I. | | | | sably 4 DUnknown |
| that that | | | | | | | | | | 108 2LINO | 3 Prot | sably appointnown |
| I Records, P.O. Box The law requires that the death cer site has been signed by the attendir page 2 should be detached for use Completed by Physician/A | | | | | | | | | 24a. Was | an autopsy | | ere autopsy findings |
| The law require tate has been signated as completed. | | | | | | | | | perlo | rmed? | COI | allable prior to mpletion of cause |
| He law | | | | | | | | | | | | death? |
| | | | | | | | | | 101 | es 2000 | 1[| Yes 2□ No |
| VITAL I | | ase referred to medica er? | - | | | | 04 | | eath (Check only o | ne) | | |
| T T T | | | | - | ER/Outpatie | | DOV | | Home 5 Resid | | | 1) |
| Affects funeral funeral | 27. Menne | tural 5 Pendir | | of Injury th, Dey Year) | 28b. Time | | 28c. Inju Wo | | 28d. Describe h | now injury occur | red | |
| Sio seath the t | 2 □ Ac 3 □ St | | not be | | | М | | Yes 2 □ No | | | | - |
| Division (but or Attending P rs after death. at Director: After t led in by the funer. Certification: | 4 □ Ho | dotorr | ined 289. Plece | of Injury - At It ng, etc. (Speci | nome, ferm, s ify) | treet, fect | ory, office | | 281. Location (S City or Tox | | per or Rura | I Route Number, |
| | | ier p⊠Certifyin | ng Physician: To the | best of my kn | owledge, dee | th occurre | d at the ti | me, date end plac | e, and due to the | cause(s) and ma | anner as st | ated. |
| he Hosp in 24 hou he Funer pletely fil | | ∠ Medicat | Examiner: On the band men | ner steted. | PROTEIN BLICKOL II | ivez(ige() | лі, иі my (| диноп, цөөп осс | Juried at the time, t | Date and place, | and due to | ure Cause(5) |
| To the vithin 2 To the comple | 29b. Signe | ture end title of certifie | / | | | | 9c. Licens | | | 29d. Date signe | d (Month, I | Day, Year) |
| | | de | Zemors | | | | 022 | 5856 | 0 | merry | 8, 2 | 000 |
| 6 15 4 | 30. Neme t | and address of person | who completed caus | e of deeth (Ite | m 23a) (Type | | | | | | -/ | |
| | | y I. Levir | | | | | Col | umbia, M | d 21044 | | | |
| State | | ed (Month, Dey, Year) | 32. F | egistrer's Sign | eture | | | will the Til | 4.2.1.74 | | | |
| Registrar | | JAN 1 (| 2000 | house | v 1 | 4 | 1 | | | | | |

DHMH 16 Rev 6/95

MARLOWS Jones of Sparings

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Meinzer Quesada shirley 0607 2000 January 14 4b. City, Town, or Location of Deeth 4a. Fecility Neme (If not institution, give street and number) 4c. County of Deeth FLKton 405P. UNION TAL CECIL If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) If Under 1 Yeer 5. Social Security Number 6. Sex 7. Age (In yrs. last birthdey) 9. Birthplece (State or Foreign 1 M 2 F Months Deys 577-12-1456 Usuel Residence of Decedent Yre 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2₽No CECIL ELKTON 10e. Street end Number 10f. Zin Code 10g. Citizen of Whet Country? NNE Shores K L.S.A 12. Wes Decedent Ever In U.S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Reca - American Indien, Bleck, White, etc. 11. Maritel Stetus 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: 1 Never Merried 2 Merried 1□ Yes 2₽No 3 ☑ Widowed 4 ☐ Divorced WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) HOMEMAKER 12 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) IKUIN9 QUESADA DOSOThy 19e. Informent Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MEINZER-SON 0 59 KICHAIO Sholes ELK TON MD. 21921 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Ferfis INC 21. Signature of Funerel Service Licanses cour UNEIAL HOME 259 E. MAIN ST. ELKTONMO 23a. Pert1. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximete Interval Between Onset and Deet Immediate Cause (Final disease or condition resulting in deeth) Myocardial Hours Due to (or es e consequenca of): Hours Apotension
Due to (or es e consequenca of): Sequentielly list conditions, if eny, leading to Immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest Day Gastrointestinal Due to (or es e consequenca of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings eveileble prior to completion of cause of death? 24e. Wes en eutopsy performed? Recent Right hip replacement 1 Yes 2 No 1 ☐ Yes 2 ☐ No

/Medical Examiner ician and burial-transit physician a Records, P.O. Box 68760,

has

certificata

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director,

Division of Vital

Physician

Examiner Physician/Medical by Completed Be 10 Certification:

1 Neturel

2 Accident

4 Homicide

(Check only one)

3 Suicide

29a. Certifier

Physician

/Medical

10e. Stete

MD.

Director

à

Completed

Examiner

Funeral

Director

the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Manylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show eny injury or rother traumatic event, its Med and its more marked to any injury or rother traumatic event, its Med and

Saltimore, Maryland 21215-0020

Hypertension 25. Wes case referred to medical Hospitel: 1 Yes 2 No 1 № Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Dete of Injury (Month, Dey Year) 27, Menner of Deeth 28b. Time of

26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify)

28d. Describe how injury occurred 28c. Injury et Work? 1 ☐ Yes 2 ☐ No

281. Location (Street end Number or Rurel Route Number, City or Town, Stete)

11 certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end pieca, end due to the ceuse(s) and menner es stated. 2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, death occurred at the time, date and placa, end due to the cause(s) end menner stated. 29c. License number

28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify)

29b. Signature and the of certified

5 Pending Investigetion

6 ☐ Could not be determined

D 30291

29d. Date signed (Month, Dey, Year)

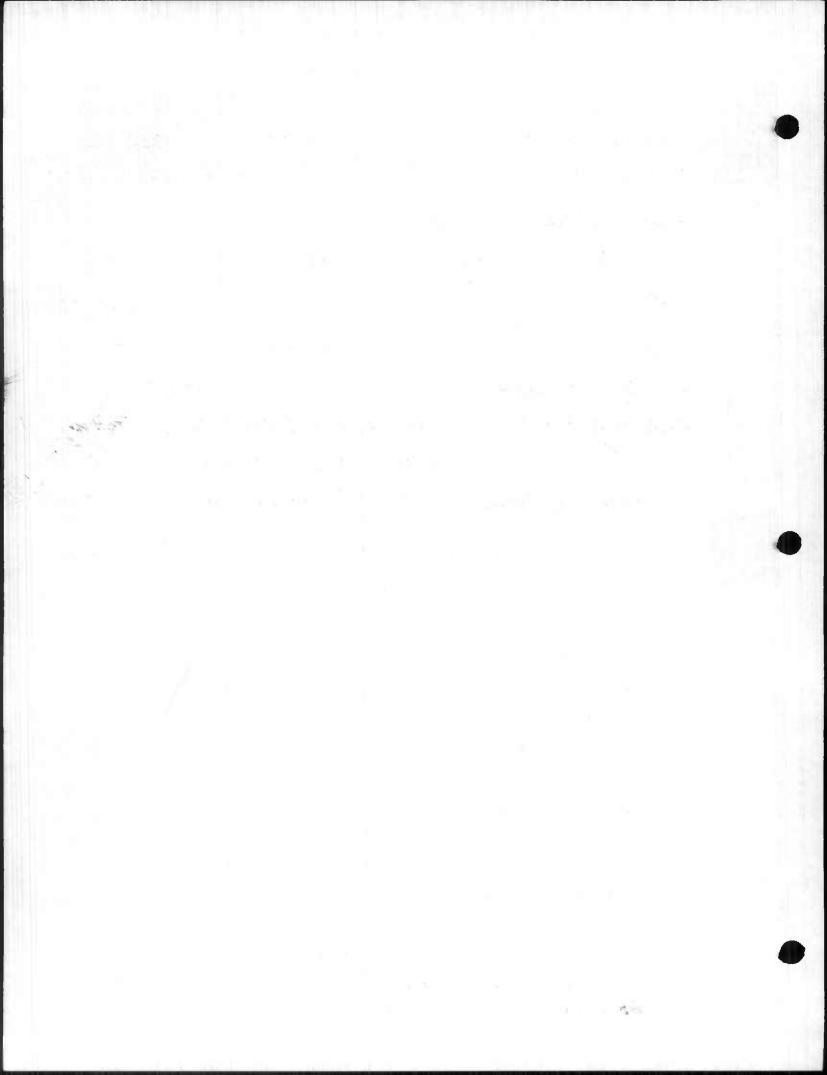
30. Neme and address of person who completed cause of deeth (Item 23e) (Type, Print)

111 W. High Street, Elkton, Maryland 21921 enitzio, 32. Registrer's Signeture

State Registrar

Medical

20



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible

| , | Type of Trink in black indelible lik. Assure All Copies Are Legible. | 0 | 0 | 0 | C |
|---|--|---|---|---|---|
| | State of Maryland / Department of Health and Mental Hygiene 0 | 2 | 3 | 3 | 1 |
| | Contilients of Dooth | | | | |

| | | | | | | Certifi | cate of | Death | | Reg. No. | | |
|------------|---|------------------|--|--|----------------------|----------------------|-----------------------------|---------------------------|--|--------------------------------|-------------------------------|---|
| | Division | | 1. Decedent's Name (First, Middle, L | ast) | | | | | 2. Date o | f Death | Van | 3. Time of Death |
| | Physic /Medi | | Regina | Α | t ennig | | | | Janu | , | 1 200 | 4.1.1.0 |
| | Exami | | 4a. Facility Nama (If not institution, ga | and the second second | | | | | vn, or Location of D | | County of Dea | |
| | | | Union Hospital | of Cecil C | County | | | Elkt | | | Cecil | |
| | Funeral Director | | 5. Social Security Number 6. 209-14-6092 Usual Residence of Decedent | Sex 7. Ag | e (In yrs. last birl | | Undar 1 Yaar onths Days | | Min. (Month | Birth Day, Year) TY 24 | 0 | rthplaca (State or Foreign Country) ennsylvania |
| | yland wow | - | 10a. Stata 10b. County | | 10c. City, Towr | or Locatio | n | | | | | 10d. Inside City Limits |
| | Men | tor | Delaware New | v Castle | Newa | rk | | | | | | 1 ☐ Yas ACNO |
| | ours ofter deeth with the Menylan el, or items 23a or 28a-f show Examiner inter to mortified | Funeral Director | 10e. Street and Number 25 Wenark Drive | | | 10 | 0f. Zip Code 1971 | 3 | | | ted St | |
| | deep # | ner | 11. Marital Status | 12. Was Decedent I Armed Forcas? | Ever in U,S. | 13. Was I | Decedent of I | lispanic Orig | In? (Specify Yas o | No- 1 | | ancan Indian, |
| 21215-0020 | filed within 72 hours efter deeth with the Meryland thygiene. ther than "naturel", or ferms 23s or 28s-f show ont, the Medical Examiner must be notitled | b | 1 Never Marriad 2 Married 3 Widowed 4 Divorced | 1 Yas 2 124 If Yes, Give Year or Datas: | Мо | | rea 25 No | | Puarto Rican, etc. | | Black, Who | |
| 5-0 | 72 h | etec | 15. Decedent'a E (Specify only highest gi | iducation rade completed) | 16a. | (Give kind | Usual Occup of work done | during most | of working | 16b. Kir | nd of Business | s/Industry |
| 121 | Aithin Par | Completed | Elementary/Secondary (0-12) | College (1-4or 5 | | life. DO N | IOT use retire | od) | | W | ollen 1 | Mill |
| | iled v tygie ther t | | 6 17. Father's Name (First, Middle, Las | | L | oom o | perato | | to blama (First 11) | | | 7111 |
| Maryland | ges 1 and 2 should be filed within 72 ho t of Health and Mentel Hygiene. If item 27 is marked other than "natur or other traumatic event, the Medical | To Be | Bernard McGove | ern | | | | | 's Name (First, Mic y Ann Ha | | sumame) | |
| Mar | l 2 sh end ls m | | 19a. Informant's Name/Relationship | | | | | | or Rural Route No | | | |
| | Health Health em 27 I | | Regina T. Vail/I | augnter | 20b. Place of | | | ive, N | lewark, D | | | |
| Baltimore, | permit. Pages 1 end Department of Health Important: If item 27 any injury or other tr once. | | 1 M Burial 2 Cremation 3 L 4 Donation 5 Other (Special | | cemeter | y, cremator | y or other pla | | Park 1/13 | | cation - City o | Maryland |
| Bal | Depar Impor any in | | 21. Signature of Funeral Service Lice | . Hicki | | Hic | ks Hom | e for | Funerals | , P.A. | Marvla | nd 21921 |
| | | | 23a. Part1. Enter tha disease, or con shock, or heert failure. List only | inplications that ceused | the deeth. Do n | | | | | | | Approximata fnterval Between |
| | Physician | | | | | | | | | | | Onsat and Death |
| | /Medical Examiner | | Immediate Cause (Final disease or condition | a. Pne | unicei | 4 A C*I | | | | | | 10 degs |
| | LAGITHIE | L. | resulting In death) | | Due to (or es a c | | e of): | | | | | 0 |
| | ed sit | -lue | | b | | | | | | | | |
| | the deeth certificate be executed y the ettending physician end tched for use as the buriel-transit | Examiner | Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury | onsequenc | e of): | | | | | 4-41-1-41 | | |
| 68760, | sician burie | | Cause (Disease or Injury that initiated events | C | | | | | | | | |
| 68 | ficate g phy ss the | Medical | resulting In death) Last | ' | Dua to (or as a c | onsequence | e of): | | | | | |
| Box | nding use a | Ž | | d | | | | | | | | |
| œ. | deeth ce | Cla | Part if. Other significant conditions | contributing to death h | it not resulting In | the underly | vlog cause ch | uen in Pert I | 23h | Old tobacco | use contribut | te to the cause of death? |
| 0 | t the d | Physician/ | | John Dating to dodt De | at not rasulting in | the arroom | ying causa gi | vali ii i ait i. | | | | Probably 4 Unknown |
| S, P | es thet igned t be det | ру Р | | _ | | | | | | 2, | 260 00. | TO SHARE |
| Records, | aw requires been s | Completed | | | | | | | 24a. V | Vea an autopenformed? | sy 24b. | . Were autopsy findings evailable prior to completion of causa of death? |
| | 0 - 0 | mo; | | | | | | | 1 | ☐ Yes 2 | No | 1 ☐ Yes 2 ☐ No |
| Vital | ysician: The sectificate director, pag | Bec | 25. Was case referred to medical | | | | | 28. Place | of Death (Check of | nly one) | | |
| of V | 5 00 | 10 | examiner? | Hospital: 1 Mapatie | nt 2 ER/Out | patient 3 | DOA Ot | her: 4 Nun | sing Home 5 F | Residence 6 | Other (Sp. | ecity) |
| ion o | g te | | 27. Manner of Death 1 ☑ Naturel 5 ☐ Pending 2 ☐ Accident Investigation | 28a. Date of Injur (Month, Day | Year) 28b. T | ime of njury N | 28c. fnju Wo | ryat rk? ∣Yes 2 🗆 N | | lbe how injury | occurred | |
| Division | | Certification: | 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | | on (Streat and Town, State) | | Rural Routa Number, |
| | To the Hospital or within 24 hours effe To the Funerel Dir completely filled in | edical (| 29a. Certifier (Check only one) 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and plated and plate and p | | | | | | place, and due to n occurred at the til | the cause(a) me, date and | end manner a place, and du | es stated. te to the cause(s) |
| | withii To th | Me | 29b. Signatura and title of certifier 29c. Licansa number | | | | | | | 29d. Date | signed (Mor | oth, Day, Year) |
| | | | I fui chil How MD D04 | | | | | 482 | 3 | 11 | 13/2 | .000 |
| | 2 | | 30. Name and address of person who | completed cause of de | eath (Item 23a) (| Type, Print) | | | st. Ell | Char | | |
| | Sta | te | 31. Date filed (Month, Day, Year) | | ur's Signature | 100 | 200 1 | , and | -0,01 | 700 | , , , | 110 |
| | Registr | ar | JAN 1 4 2000 | A STATE OF THE STA | N. | jago | unco | | | | | |

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day John T. Myerly January 9, 2000 12:55 A.M. 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Genesis Eldercare at Spa Creek Annapolis Anne Arundel 6. Sex 1 M 2 □ F If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Min. Hours Months Davs 577-16-1473 Feb. 4, 1920 Washington, Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Anne Arundel Edgewater 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1720 Quantico Road USA 21037 12. Was Decedent Ever in U,S. Amed Forces? 1 ဤ Yes 2 □ No If Yes, Give Year or Dates: W. W. II 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black White etc 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12th Paper Recycler Recycling 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John Tyler Myerly Betty Carberry 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1720 Quantico Road Selma Mverly/ Wife Edgewater, Maryland 21037 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Lakemont Meml. Gardens 1-12-00 Davidsonville, MD 22. Name and Address of Facility
George P. Kalas Funeral Home 21. Signature of Funerel Se 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Death Immediate Cause (Final 2 month · Metutatu asunome disease or condition resulting in death) Keine Due to (or as consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 DUnknown 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 1 Yes 2 50No 1 ☐ Yes 2 No 26. Place of Deeth (Check only one) Hospitel: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 412/Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

Examine attending physicien and for use as the buriel-transit Box 68760 Physician/Medical Division of Vital Records, P.O. 3 signed t P Completed peen page 2 hes of Vita.
....ospital or Attending Physician: Th. Thin 24 hours after death.
The Funeral Director: After thin Notely filled in poor. certificate Be 10 Certification: To the Hospital o within 24 hours af To the Funeraf Di

Physician

/Medical

Examiner

Director

Funeral

p

Completed

Be

Funeral

Director

7 is marked other than "natural", or items 23s or 28s-f show traumstic event, the Medical Examinat must be notified at

pernit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: if fem 27 is marked other than "y any fijury or other traumatic event, in a Mode.

Physician /Medical

Examiner

the Marylend

72 hours after

Baltimore, Maryland 21215-0020

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 DeNatural

29e. Certifier (Check only one)

4 Homicide

1X Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

29b. Signature and title of certifi

29c. License number D 38958

29d. Date signed (Month, Day, Year) 2000

State Registrar

Medical

Daf est Sing 31. Date field (Month, Day, Year) JAN 1 1 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dal, est Sup L Frehu 1413 Anno 10 Annopolis 32. Registrar's Signature

Road #106 odenten MD 81113

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 2337

| | | Decedent's Name /First Mid | | | | | | | | | | | | | |
|--|--|--|---------------------|---|--|--|--|--|---|-----------|--|--|---|---|--|
| ıysician | _ | 1. Decedent's Neme (First, Middle, Last) Sharon Marie Nash | | | | | | | | | 2. Dete of D Month | Dey | | Yeer | 3. Time of Death |
| Medical | 1- | | | | | | | | | | Janua | 4 | | 000 | 08:58 A. |
| caminer | r 4 | le Facility Neme (If not Instituti | 1000 | | | | | | | | cation of Dec | th 4c. (| County o | | . 479 |
| - 2 | | | - | ast Ma | | | lf Line | dar 1 Yaar | Wes | | ster | | | rrol | |
| neral | - | 5. Social Security Number 218 – 54 – 3561 | 6. Se | ex □M 2/□XF | | yrs. last birthd | Month | | Hours | Min. | 8. Data of B (Month, D Oct. | ley, Year) | 1050 | 9. Birthp | placa (Steta or Forei |
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death 3. Tima of Death 1 Decedent's Nama (First Middle Last) 17, 2000 Physician 6:30 p.m. Lewis Peter Newman January /Medical 4b, City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not Institution, give street and number) Examiner Moran Manor Nursing Home Westernport Allegany if Undar 1 Yaar | If Undar 24 Hrs. 5. Social Sacurity Number 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) **Funeral** Days Hours 1 M M 2 F Yrs. 216-07-8081 **Director** 84 Apr 12, 1915 Pennsylvania Usual Rasidance of Dacedant the Manyland 10a. Stata 10c. City, Town or Location 10d. Inside City Limits 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumetic event, the Medical Examinat must be notified at 1 ☐ Yas 2 No WV Mineral Keyser Director 10f. Zip Coda 10e. Street and Number 10g. Citizan of What Country? with 26726 Route 4, Box 40 USA permit. Peges 1 end 2 should be filed within 72 hours after death bepartment of Health end Mental Hygiena. Important: If Item 27 is merked other than "natural", or Items 23. Funeral 12. Was Decedant Evar in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian. 11. Marital Status Black, Whita, atc. 1 ⊠ Yas 2 □ No
If Yas, Giva
Yaar or Datas: 1943–45 1 Nevar Marriad 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 to No Specify: P 3 ₩ Widowed 4 Divorced white Completed 15. Decedant's Education (Specify only highast grada complated) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b Kind of Business/Industry Il Hygiena. Elamantary/Secondary (0-12) Collega (1-4or 5+) Shipping Clerk Paper Manufacture 8 th 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Frank Newman Sally May 19a. Informant's Name/Ralationship (Typa, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Jeffrey D. Rhodes/ stepson 23 Race St., Cumberland, MD 20b. Placa of Disposition (Nama of camatary, cramatory or other placa) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 X Burial 2 □ Cramation 3 □ Ramoval from Stata ò Salisbury Cemetery, Jan. 20,2000 Salisbury, PA any Injury o 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Sarvice Licansaa 22. Nama and Addrass of Facility Newman Funeral Homes, P.A., PO Box 275 00 179 Miller St., Grantsville, MD 21536 23a. Part1. Effar the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest shock, of heart failure. List only one cause on each line. Approximata Intarval Between Onset and Death **Physician** my ocardial Infarction /Medical Immadiata Causa (Final disease or condition rasulting in death) Route 30 minute Examiner Dua to (or as a consequanca of): Examiner certificate be asscuted as the burial-transit Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaasa or Injury that Initiated avants rasulting in daath) Last Dua to (or as a consequence of): pue physicien Physician/Medicai Dua to (or as a consequence of): use i Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23b. Did tobacco use contribute to the cause of death? signed by Division of Vital Records, à 8 24b. Wara autopsy findings available prior to 24a. Was an autopsy performed? Completed completion of causa of death? page 2 certificate hes 1 Yas 2 No 1 ☐ Yas 2 ☐ No 25. Was casa rafarred to medical axaminar? 26. Placa of Daath (Check only ona) Be Other: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) 10 1 Yas 3 No 1 Inpatiant 2 ER/Outpatient 3 DOA this funeral 28d. Dascribe how injury occurred 27. Mannar of Death 28b. Tima of 28c. Injury at Work? 28a. Data of Injury (Month, Day Year) Certification: After or Attending 10 Natural 5 Panding s efter death. 1 Yas Invastigation Accident 6 Could not ba datarmined 3 ☐ Suicida 281. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, streat, factory, offica building, atc. (Specify) filled in by 4 Homicida within 24 hours of To the Funeral I the Hospital Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Madical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical completaly (Check only one)

hus

30. Nama and addrass of person who complated causa of death (Itam 23a) (Type, Print) Jesus H. Tan, M.D., 10701 New Georges, Creek Rd., SW, Ste 3, Frostburg, MD

31. Data filad (Month, Day, Year) JAN 1 9 2000 Registrar

29b. Signatura and titla of cartifiar

32. Registrar's Signalara

29c. Licensa number

D21244

29d. Data signed (Month, Day, Year)

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Tima of Death Day Month Year **Physician** Nixon George JANUARY 10, 2000 21:37 /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MEMORIAL HOSPITAL CUMBERLAND ALLEGANY 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Mar 20, 1911 Birthplece (State or Foreign Country)
 MD 5. Social Security Number **Funeral** Months Days Hours 10M 20F Yrs 214-05-5741 88 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits works / 10b. County r than "natural", or items 23s or 28s-f ahor 1 Yes 2 No Directo Allegany Cumberland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21502 405 Seymour Street USA deeth 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, a filed within 72 hours efter di Il Hygiena. other than "natural", or frem Bleck, White, etc. 1 Never Married 2 Merried Baitimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: white by 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) . Pages 1 and 2 should be filled will ment of Health and Mertel Hygien lant; if item 27 is marked other the jury or other treumatic event, as Owner/Operator Grocery Stores 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) George Marshall Nixon Ella R (Arnold) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) Janet Crabtree 405 Seymour Street; Cumberland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Dete 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removel from State permit. Page Department of Important: If eny Injury or page. 4 □ Donation 5 □ Other (Specify) Davis Memorial Cemeter1/13/ Cumberland, MD 21. Signature of Funeral Service Licent 22 Scarpelli Funeral Home P.A. Cumberland, Maryland 23a. Pert1. Enter the disease, or complications that caused fall shock, or heart leiture. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death **Physician** /Medical tmmediate Cause (Finat disease or condition resulting in death) a. Hypoxemia 1 hour Examiner Due to (or as a consequence of): Examiner 48 hours b Exacerbation of chronic obstructive pulmonary disease requires that the deeth certificate be assecuted physician and the burlatransit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Vital Records, P.O. Box 68760. 4 days c. By pass surgery for foot ischemia Physician/Medical Due to (or as a consequence of): for use as 10 years dPeripheral vascular disease signed by the e 23h. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown Metastatic prostate cancer. Paraplegia. Spinal þ should ! 24b. Ware autopsy lindings aveilable prior to completion of cause of deeth? 24a. Wes an autopsy performed? Completed stenosis 1 Yes 2 1€No 1 Yes 2 No Attending Physician: 8 25. Was case referred to medical axaminer? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Othar (Specify) 1 Yes 2 HO 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Division of this 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? After 5 Pending 1 ANaturat death. To the Hospital or Attandi within 24 hours after death. To the Funeral Director: A completely filled in by the fu investigation 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28l. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Cortifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dev. Year) wall. JANUARY 15, 2000 053158 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MIS 21502 CUMBERLAND, MD 924 SETON DRIVE, DR. MICHAEL W. STASKO, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 16 Rev 6/95

Registrar

JAN 18 2000

GEORGE NIXON

and the second will be the

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State of Maryland / Department of Health and Mental Hygiene 00 02340

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| /Medi Exami | | 4a. Facility Nema (If not Institution, g | ive street and numbar, | | | | 4b. City, Town, o | r Location of Death | 40. County | of Death | |
| | | Shady Grove Ad | lventist | Hospi | tal | I | Rockvil | 1e | Montg | gomery | |
| Funeral Director | | 573-34-2122 | Sex 7. Ag | ga (In yrs. las 72 | | Undar 1 Year Ionths Days | If Under 24 Hr Hours Min | | th y, Year 1927 | 9. Birthplace Country Wasni | (State or For |
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| 48 | jo | Wash. None | | Wash | ingto | n, DC | | | | | Yes 2 |
| r 28a | Director | 10e. Street and Number | | | 1 | 10f. Zip Coda | | | 10g. Citizen of | What Country? | |
| 23a o | aiD | 7301 Alaska Av | enue, NW | | | 20012 | | | USA | | |
| al', or items 23a or 28a-f show Exercicer mant be notified at | by Funeral | 11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced | 12. Was Decedent Arroed Forcas' 1 Tyes 2 Telegraphic If Yas, Giva Yaar or Dates: | No | | Decedant of Hes, specify Cubi | tispenic Origin? (an, Mexican, Pua Spacify: | Specify Yes or No irto Rican, atc.) | | ca - Amarican Ir ck, Whita, atc. v: Whit | |
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| 7 is trau | | 19a. Informant's Neme/Relationship Craig Fry/Neph | lew | | | | | Rural Routa Number Lexing t | | 2729 | |
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| int: If its | | 1 ☐ Burlal 2 ☐ Cramation 3 ☐ 4 ☐ Donation 5 ☐ Othar (Spec | Removal from Stete | No . V | A. Cr | emato | ca) Cy | 11,2000 | | | |
| Init | | 21. Signature of Funeral Service Lice | ** | | 22; Na | ama and Addra | ss of Facility | 1 Home | | | |
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State of Maryland / Department of Health and Mental Hygiene 0 0 2 3 4

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| | 0 11 | | 1. Decedent's Name (First, Middle, Li | | | 1- 1 | | | 2. Date of D | eath | Voca | 3. Ti | me of Death |
| | Physic /Medi | | MAX H | NO | VINS | SKY | | | JAN |) · 0.7 | - 200 C |) 5 | 5 pm |
| | Exami | | 4a. Facility Neme (If not institution, gir | | | | | | or Location of Dea | th 4c. Co | ounty of Death | | 1 |
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| | uneral irector | | 052-18-3550 | Sex 7. Age 1 M 2 F | 8 0 | | Inder 1 Year oths Days | | 8. Date of B in. (Month, I May | irth Year) 0, 19 | 1 9. Birth | nplace (Suntry) (EW | itete or Foreign York |
| pue | 2 | | Usual Residence of Decedent 10a. State 10b. County | | 10c. City, Tov | vn or Location | | | | | | 10d Insi | de City Limits |
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| the | 28a | Director | 10e. Street and Number | gomery | I.C | | . Zip Code | | | 10a Citize | n of What Cou | unto/2 | |
| ath with | 23a or | | 1235 Potomac | | | | 2 | 0850 | | Un | ited S | Stat | |
| 21215-0020 d within 72 hours after death with the Marylend | "natural", or items 23a or 28a-f ahow od cal Examiner must be notified at | by Funeral | 11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced | 12. Was Decedent B Armed Forces? 120 Yes 2 N If Yes, Give Year or Dates:1 | lo | 404 | ecedent of I specify Cub es 2 No | | (Specify Yes or Nerto Rican, etc.) | | Race - Amer Black, White pecify: W1 | | |
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| | T is m traum | | 19a. informant's Name/Relationship (Gordon Novinsi | ** | 198 | b. Meiling Add | dress (Street carle | end Number or t Sage | Rural Route Number Ct. El | ber, City or T lico | own, Stete, Zitt Cil | ip Codep ty, M | 1042 |
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| alti | inju | | 21. Signature Funeral Service Lice | | | | | | akoma I | | | | |
| m & & | any ir | | Henry o | Dep | ain, | 254 | Carr | oll St | . NW Wa | shin | gton, | DC | 20012 |
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| oentifica | attending pl | √Mec | | d | | | | | | | | | |
| death | d for u | Physician/ | Part II. Other significant conditions of | ontributing to death bu | t not resulting i | in the underly | no cause ob | van in Part I | 23h Dia | I tohacco us | e contribute | to the co | use of death? |
| O E | ad by the atte dateched for | Phys | | orning to double bu | t riot rooming i | in the underly | ng oddso gn | on an anti- | | 2011/1 | | | 4€\Unknown |
| | 5 2 | by | | | | | | | | | | | |
| Vital Records, | s peen s | Completed | | | | | | | 24a. We per | s an autopsy ormed? | 87 | vallable p | ppsy findings brior to n of cause |
| I Red | ate has page 2 | шо | | | | | | | 10 | Yes 2 🖺 | | □Yes | 2□ No |
| | certificate rector, pag | | 25. Was case referred to medical | | | | | 26 Place of F | Death (Check only | | , | L 103 | 2010 |
| of Vita Physician: | | o Be | examiner? 1 Ves 2 No | Hospital: 1 ☐ inpatier | . a□ED/O | | DOA Oth | ner | | | 700 (0 | 16.3 | |
| | 두 교 | 1: To | 27. Manner of Death | 28e. Dete of Injur | y 28b. | Time of | 28c. Injui | | Home 5 Res 28d. Describe | | | ny) | |
| O de de | Afte: | tlor | 1 Neturel 5 ☐ Pending investigatio | (Month, Dey | | injury M | | rk? Yes 2 □ No | | | | | |
| DIVISION To the Hospital or Attending within 24 hours after death. | To the Funeral Director: After completaly filled in by the fune | Certification: | 3 Sulcide 6 Could not be determined | e Ogo Diego of Inju | ry - At home, fa (Specify) | arm, street, fa | ctory, office | | 28f. Location City or To | (Street end f own, Stete) | Vumber or Ru | rel Route | Number, |
| Ospital o | Delli | | | | | | | | | | | | |
| Ne Hos | e Funeral | edical | 29a. Certifier 1 ☐ Certifying Ph (Check only one) 2 ☐ Medical Exam | yaician: To the best of niner: On the basis of end manner stat | examination an | e, deeth occu nd/or investige | red at the til ition, in my c | me, dete and ple opinion, death oc | ce, and due to the curred at the time | cause(s) en , dete end pl | d manner as ace, and due | steted. to the car | use(s) |
| To the within | To the | Σ | 29b. Signature and little of pertitier | 0 0 | 1/ | | 29c. Licens | se number | | 29d. Date s | signed (Month | , Dey, Ye | ier) |
| 1 | | | 1/1/ | Len | Le | w | D s | 52261 | | Janu | ary 9 | . 20 | 000 |
| 121 |) | | 30. Name and address of person who | completed cause of de | eth (Item 23a) | (Type, Print) | | | | 5 3 11 4 | | - | |
| 6 | | | Dr. R. Segal | | | | ley F | Rd. Roc | kville | MD 2 | 0850 | | |
| - | Sta | te | 31. Date filed (Month, Dey, Yeer) | | r's Signature | | | | | | Of I | | |
| | Registr | ar | JAN 1 0 2000 | Sher | ~ 0 | . 140 | rals | | | | | | |

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State of Maryland / Department of Health and Mental Hygiene 00 02342

| | | | | Ce | rtificate | of i | Death | | Reg. No. | 0 | J (, O -7 1 | |
|-------------|--|--|---|--|---|----------------|--|---|--|---|--|--|
| | Physician | 1. Decedent's Nama (First, Middle, L Thomas A. | ast) 01e | | | | 2. Data of D Month Jan. | eath Day | Year 000 | 3. Time of Death 2:30 A.M. | | |
| | ∹ /Medical Examiner | 4a Facility Name (If not institution, g. 6710 Highbridge | | | | 1 | Bowie | r Location of Dea | th 4c. County | y of Death | orge's | |
| | Funeral Director | 011 34 0745 | Sex 7. Age | 6 (In yrs. last birthday) 57 Yrs. | If Under 1 Months E | Year | If Under 24 H | | irth av. Year) 4, 1942 | | place (State or Foreign ntry) sachusetts | |
| | e Maryland and ahow wheel at | Usuai Residenca of Decedent 10a. State 10b. County Maryland Prince | George's | 10c. City, Town or Lo Bowie | ocation | | | | | | 10d. Inside City Limits | |
| | after death with the Ma in theme 23a or 23a-f s infer must be noutlies Funeral Director | 10e. Street and Number 6710 Highbridge | e Road | | 10f. Zip Co | | 0720 | | | Citizen of What Country? | | |
| 020 | by | 3 ☐ Widowed 4 ☐ Divorced | 12. Was Decedent Armed Forcas? 1 Yas 2 1 1 Yas, Give Yaar or Dates: | | Was Deceden If Yes, specify 1 ☐ Yes 2 | | lispanic Origin? an, Mexican, Pus Specify: | (Specify Yes or Norto Rican, atc.) | Bla | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 21215-0020 | C | 15. Decedent's E (Specify only highest given the secondary (0-12) | rade completed) | +) (Give | DO NOT use i | done | during most of w | rorking | 16b. Kind of Business/Industry | | | |
| Maryland 2 | Be file | 17. Father's Name (First, Middle, Last) Andrew S. Oleksak Emil 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number) | | | | | | | U.S. G e, Maiden Suman borski | | iment | |
| _ | 2 4 6 | | (Туре, Print) Wife | | | | | Rural Route Num Bowie M | | | | |
| Baltimore, | Page nent of int: If iry or | 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Special Control of Control | | 20b. Place of Disponentery, cre St. Mary | matory or othe | or plac | | 13, ^D 2000 | 20c. Location Westfi | | | |
| Balt | permit. Pag Department Important: It any Injury o | 21. Signature of Funeral Service Lice | Down | - 1 | | | | uneral H d. Bowie | | | 715 | |
| | Physician | 23a July . Enter the disease, or of the disease, or heart tailure. List one | | the death. Do not en | ter the mode of | ot dylr | ng, such as card | ac or respiratory | arrest, | 1 | Approximate tnterval Between Onset and Death | |
| | /Medical Examiner | tmmediate Cause (Finat disease or condition resulting in death) | a acute | mystard Due to (or es a conse rio Schl | quence of): | 14 | darde | 50 | | | 6 | |
| x 68760, | death certificate be executed attending physician and id for use as the bunal-transit | Cause (Disease or injury that initieted events resulting In death) Last | C | Due to (or as a conse | quence ot): | | neare | aise | OSE. | | 5 yours | |
| P.O. Bo | the d | | contributing to death bu | ut not resulting in the u | inderlying cau | se giv | en in Part I. | | 23b. Did tobacco use contribute to the c | | | |
| Records, | been sign should be | | | | | | | 24a. Wa | s an autopsy formed? | a) C | /are autopsy findings valiabla prior to empletion of cause i death? | |
| of Vital Re | ysician: The law is certificate has b director, page 2 s director. De Compli | 25. Was case reterrad to medical | | | | | 26 Piace of C | 1 Ceath (Check only | Yes 2 No | 1 | ☐ Yes 2☐ No | |
| <u>></u> | | examiner? | Hospitel: 1 Inpatie | nt 2 ER/Outpatie | nt 3 DOA | Oth | | | stdence 6 🗆 Ot | her (Speci | (fy) | |
| Division o | fer thi | 27. Manner of Death 1 Naturel 5 Pending 2 Accident investigation 3 Suicide 6 Could not | | Year) 28b. Time of Injury | M 28c | . Injur Wor | yat rk? Yes 2 □ No | | a how injury occu | | | |
| Divi | To the Hospital or Attendiviting 24 hours after death. To the Funeral Director: A completely filled in by the it. Medical Certificati | 4 Homicide determine | building, etc | | | | | City or T | own, Stefe) | | al Routa Number, | |
| | To the Hospital within 24 hours or To the Funeral I completely filled | (Check only 2 Medicat Exa | hyeiclan: To the best of iminer: On the basis of and manner sta | examination and/or in | vestigation, In | my o | ppinion, death oc | ce, and due to th curred at the time | , date and place | , and due I | to the cause(s) | |
| | To with the common of the comm | 29b. Signature and title of certifier R - Dak | Theil 1 | n.) | 296. [| 2 | 649 | 2 | 29d. Date sign | Month, | Day, Tear/ | |
| _ | (15) | Kind Datheel n | | Mitchel | Print) | 2 | Rd, B | owie, | MDZ | 07/ | 6 | |
| | State Registrar | 31. Dete tiled (Month, Day, Year) JAN 1 0 2000 | | er's Signeture | lon | 6 | - | | | | | |

DHMH 16 Rev 6/95

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| | | | | | | ertificate d | or Death | | Reg. No. | | |
|--|----------------|--|----------------------------------|---|---------------|---------------------------------------|--|------------------------|--------------------|------------|---|
| Physici | ian | Decedent's Neme (First, Middle, Landson, La | ist) | | | | | 2. Dete of De Month | Day | Yeer | 3. Time of Death |
| /Medi | | Mary Christy | Otto | | | | | January | 7 200 | 0 | 5:10 PM |
| Examir | | 4e. Facility Neme (If not institution, given | e street and numb | ber) | | | 4b. City, Town, or | Location of Deeth | 4c. County of | of Deeth | |
| | | Crofton Convales | cent & R | ehab. | Ctr. | | Crofton | | Anne | Arun | del |
| Funeral | | , | | . Age (in yrs. | last birthda | y) If Under 1 Ye Months De | | | h v Year) | 9. Birthpi | ece (Stete or Foreign |
| Director | | 034-09-3077 | 1□M 2\\ F | 85 | Yrs. | Widiting De | ys modes with | May 5, | 1914 | | SS. |
| 9 | | Usuel Residence of Decedent | | | | | | | | | |
| in i | 2 | 10a. Stete 10b. County | | 10c. City | , Town or | Location | | | | 10 | Od. Inside City Limits |
| DI DE | Director | CT. Hartfor | d | W | est H | lartford | | | | | 1 ☐ Yes 2 ♠ No |
| 2 a | i e | 10e. Street and Number | | | | 10f. Zlp Cod | е | | 10g. Citizen of W | hat Count | try? |
| 38 d | a D | 35 Price Blvd. | | | | | 06107 | | US | Α | |
| illed within 72 hours after deeth with the Menyland Hygiene. Iffer than "natural", or thems 23s or 28s-f show int, the Medical Exphision must be notified a | Funeral | 11. Meritel Stetus | 12. Wes Deced | ent Ever in U, | S. 13 | . Wes Decedent | of Hispanic Origin? (Juban, Mexican, Pue | Specify Yes or No | 14. Race | - America | |
| The second | F | 1 Never Married 2 Merried | Armed Force 1 Yes 2 If Yes, Give | es? No | | | | rto Rican, etc.) | Black | , White, e | etc. |
| urs a | by | 3 ☑ Widowed 4 ☐ Divorced | If Yes, Give Yeer or Dete | es: | | 1 □ Yes 2 🔯 1 | No Specify: | | Specify: | Whi | te |
| "natural", or | Ped | 15. Decedent's E | ducation | | 16e. Dec | edent's Usuel Oc | cupation | | 16b. Kind of Bus | iness/Ind | ustry |
| C 0 | Completed | (Specify only highest gr | | \ | (Girl life | re kind of work do . DO NOT use re | cupation ne during most of wo tired) | orking | | | |
| Hygiene. Hygiene. Ather than | E | Elementery/Secondery (0-12) | College (1-4 | ior 5+) | | Sewing 1 | nstructor | | Schoo | 1 | |
| H H H | | 17. Fether's Neme (First, Middle, Last |) | | | | 18. Mother's Ne | me (First, Middle, | Meiden Sumame |) | |
| s 1 and 2 should be tiled within the fit seith and Mental Hygiene. Item 27 is marked other than other traumetic evant, the M | To Be | Michael Christy | | | | | Mary Do | nousen | | | |
| should ind Men imarke umetic | F | 19e. Informent's Neme/Rejetionship | Time Print | - | 10h Ma | Ilina Addrose /Str | eet and Number or F | | or City or Town 6 | Note 7in | Cadal |
| d 2 s | | Paul Otto / Son | · ypo, / ///// | | | Strawbe | | | nville, | | |
| Heel ther | | 20e. Method of Disposition | | 20h P | 1 | position (Neme of | | Davidso | 20c. Location - (| | |
| permit. Pages 1 and: Department of Heelth Important: if Item 27 I any Injury or other tr | | 1 Burial 2 □ Cremetion 3 □ | Removel trom St | | emetery, cr | emetory or other | plece) | | | | |
| Tan Juny | | 4 □ Donation 5 □ Other (Special | • | F | | w Cemetery | | 01-12-00 | | | |
| Depermit Import Into | | 21. Signeture of Funerel Service Lice | nsee | | | 22. Neme and Ad | dress of Fecility Jo | hn M. Ta | ylor Fun | eral | Home, Inc |
| 66558 | | PRI | Krus | ,21 | | | of Glouce | | | | |
| | | 23a. Pert1. Enter the disease, or com | plicetions thet cau | used the deeth | | | | | | | Approximete |
| hysician | | shock, or heert feilure. List only | one ceuse on eed | on line. | | | | | | t | Interval Between Onset end Deeth |
| /Medical | | Immediate Cause (Final | | = a h = | | . 1 | Accio | 1 + | | ĺ | 1 4 |
| Examiner | М | disease or condition resulting in death) | e. C.9 | | _ | | 1/2010 | 1emi | | i | MONT |
| | ē | | | Due to (o | r es a cons | equence ot): | | | | 1 | |
| ncete be executed physician end is the burial-transit | Examiner | | b | D. 141 (1) | | | | | | 1 | |
| moste be executed physician end sthe buriai-transif | Exa | Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury | | Due to (o | es a cons | equence ot): | | | | 1 | |
| Sicial | | Cause (Diseese or Injury that Initieted events | c | | | | | | | | |
| phy s the | edicai | resulting in deeth) Last | | Due to (or | es e cons | equenca ot): | | | | | |
| | | | d | | | | | | | 1 | |
| me ceam cen y the attendin ached for use | Physician/M | | | | | | | | | | |
| mar me de ned by the a detached | ysi | Pert II. Other algnificant conditions of | ontributing to deat | th but not resu | ulting in the | underlying cause | given in Pert I. | 23b. Dtd | | tribute to | the cause of death |
| detac | | | | | | | | 10 | Yea 21110 | 3 Prob | ably 4 ☐ Unknow |
| 6 6 8 | Ď | | | | | | | | | | |
| been si should | te | | | | | | | | an autopsy med? | eva | re autopsy findings Illable prior to |
| 12 cs 1 | Completed | | | | | | | | | of d | npletion of cause leath? |
| 0 - 6 | DO. | | | | | | | 101 | res 2□ No | 10 | Yes 2□ No |
| certificate | Be | 25. Wes case referred to medical | | | | | 26. Place of De | eath (Check only o | ne) | | |
| | 0 | examiner? 1 ☐ Yes 2 ☐ Ne | Hospitei: | atlent 2 | ER/Outpati | ent 3 DOA | Other: 4 Nursing | Home 5 ☐ Resid | tence 8 □Othe | r (Specify |) |
| | T. | 27. Menner of Death | 28e. Date of | Injury | 28b. Time | | njury et Nork? | | now Injury occurre | | |
| ith. : After e funer | the | 1 ☐Naturel 5 ☐ Pending 2 ☐ Accident investigatio | | Dey Year) | Injury | | Yes 2 No | | | | |
| or Attending effer death. Director: After d in by the fune | Certification: | 3 ☐ Suicide 6 ☐ Could not b | Zee. Pleca of | f Injury - At ho | me, farm, | street, tectory, offi | ca | | Street end Numbe | r or Rural | Route Number, |
| Die | ert | 4 Homicide determined | building | , etc. (Specify | ") | | | City or Tov | vn, State) | | |
| 24 hours Funeral Kely filled | | 29a. Certifier 1 Certifying Ph | yalctan: To the he | est of my know | viedae. des | oth occurred at the | tima, date end plac | a, and due to the | cause(s) and man | ner as str | ated. |
| within 24 hours offer To the Funeral Dire completely filled in b | edical | (Check only 2 Medical Exar | niner: On the basi | is of examinet | ion end/or | Investigation, in m | y opinion, deeth occ | urred at the time, | dete and place, a | nd due to | the cause(s) |
| within 2 To the | Z. | 29b. Signeture and title of certitier | 1 | | | 29c. Lic | ense number | | 29d. Dete signed | (Month, L | Dey, Year) |
| - 3 H 0 | | 1 -1// | UN | | | 00 | 0440 | | 1 7 | 7 - | oT) |
| Y | | 111111 | | | | 1)3 | 2070 | | kin / | 40 | |
| | F | A | | | | | | | | | |
| | | 30. Name end eddress at person who | completed cause | of deeth (Item | 23a) (Typ | e, Print) | 1 | - () (| 1 1000 | 1 | |
| | | 30. Name end eddress of person who have a series of seri | nItal | of deeth (Item)749 Ilstrer's Signe | Ker | mi hyter | Dn C | nothon | mo | 211 | 14 |

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme /First, Middle Last) 2. Dete of Deeth Month 3. Time of Death Year James 728 January 2000 4b. City, Town, or Location of Deeth 4c. County of Death 4e. Fecility Name (If not institution, give street and number) Cambridge Dorchester HOSPita Dorchester (reneral If Under 24 Hrs. 8. Dete of Birth If Under 1 Yeer 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 10 M 20 F 218-20-53 8 Days Hours Min. 17,1921 Maryland Usual Residence of Decedent 10e. Stete 10b. County 10c, City, Town or Location 10d. Inside City Limits 1 Yes 2 No Dorchester 10e. Street and Number 10f. ZIp Code 10g. Citizen of Whet Country? 706 2/6/3 ORNISH USA DRIVE 14. Race - American Indian, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☑ Yes 2 ☐ No Wes Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Marital Stetus 1 Never Married 2 Married 1 Yes 2 No Specify: Yes Give Specify: Black 3 Widowed 4 □ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Supplier Garment Industry Material 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surname) Whittington John Helen 19e. Informent's Neme/Reletionship (Type, Print) 19b. Malling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 4301-23rd Parkway Apt. 107 Temple Hills, MD, 20748 Pinder Laverne 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Dete 20c. Location - City or Jown, State 1 Burial 2 Cremation 3 Removel from Stete 1/24/2000 eteran's Cemetery HURLOCK, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 22. Neme end Address of Fecility HENRU re of Funeral Service Licensee Funeral Home P.A. LENRY 510 Washington St. Cambridge Maryland 21613 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart tellure. List only one cause on each tine. Approximate Interval Between Onset and Death tmmediate Cause (Finel Terebrovasaler disease or condition resulting in deeth) Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that inifieled events resulting in deeth) Last Due to (or es e consequence ot): Due to (or es e consequence of): Pert tt. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown cercl 24b. Were autopsy tindings evailable prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes -20 No 1 ☐ Yes 2 ☐ No 25. Wes case reterred to medical 28. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1- Inpatient 2 □ ER/Outpatient 3 □ DOA 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending Investigation 1 Yes 2 No

/Medical Examiner physician and the burial-transit attending pl signed by the atte

certificate has been s director, page 2 should

To the Hospital or Attending Phy within 24 hours efter death.

To the Funeral Director: After this completely filled in by the funeral?

Pinder Philip

Examiner

Physician/Medical

þ

Completed

Be

2

Certification:

Medical

Physician

Physician

/Medical

Examiner

Funeral

Director

must be notified at

the Medical Examiner

6

permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If them 27 is marked other than "naturel", or its

Baltimore, Maryland 21215-0020

Director

Funeral

by

Completed

1 Yes 20 No

27. Menner of Deeth 1. Natural 2 Accident 8 Could not be determined 3 Suicide 28e. Pleca of Injury - At home, term, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State)

4 Homicide 29e. Certifier 🖎 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) and menner as stated.

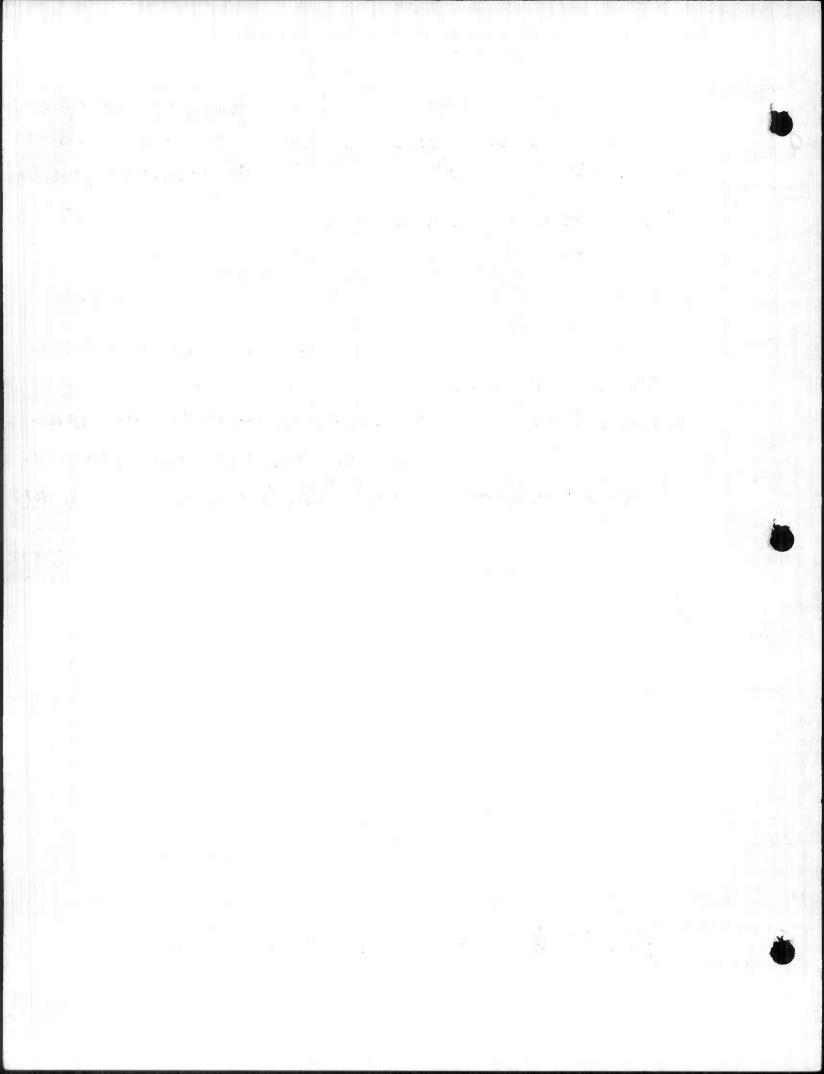
(Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) end menner stated. 29b. Signature and title of-certifie 29c. License number 29d. Date signed (Month, Dey, Year)

00

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

503 Dutchman's Lane, Easton, Md. David G. Oliver, M.D. 31. Dete tiled (Month, Dey, Year) JAN 19 2000

State Registrar 32. Registrer's Signature



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Dev Month Veer **Physician** Jan Gladys Mae Poorman 3 2000 11:58pm /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4e Fecility Neme (If not institution, give street and number) Examiner 989 Hacienda Court Westminster Carroll If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Yeer) If Under 1 Yeer 5. Sociel Security Number 7. Age (In yrs. last birthdey) Birthplace (State or Foreign Country) 6. Sex **Funeral** Months Deys 1 □ M 25 F Director 173-18-7587 18 1921 Usuel Residence of Deced with the Marylend 10e, Stete 10d, Inaide City Limits 10b. County 10c. City, Town or Location rithen "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 ¥ Yee 2 □ No Director PA Westmoreland New Stanton 10f. Zip Code 10e. Street end Number 10g. Citizen of What Country? 372 Arona Road 15672 USA Funeral death Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Rece - American Indien, Bleck, White, etc. 12. Wes Decedent Ever in U.S. Armed Forces? 11. Meritel Status 2 should be filed within 72 hours after and Mental Hygiene.
Is marked other than "natural", or Ne 1 Yes 2 No 1 ☐ Never Merried 2 ☐ Married altimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: White þ 3 Widowed 4 □ Divorced Year or Detes: Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Hempfield School Elementary/Secondary (0-12) College (1-4or 5+) Secretary District 12 17. Fether's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Meiden Sumeme) . Pages 1 and 2 should be fill ment of Heelth and Mental Hant: If item 27 is marked oth lury or other traumatic even Russell Oscar Shrader Berna Mae Kauffman 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 989 Hacienda Court Westminster, MD 21157

co of Disposition (Name of Dete 20c. Location - City or Town, Stete James Poorman/son 20b. Piece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition 1 □ Buriel 2 □ Cremation 3 ☑ Removel from State Department of important: If any injury or once. 4 ☐ Donetion 5 ☐ Other (Specify) West Moreland Memorial 1/17/2000 Greensberg, PA 21. Signature of Humbal Service License 22. Name and Address of Fecility ritts Funeral Home and Chapel 412 Washington Rd Westminster, MD 21157 23a. Part : Erver the discussion or complications that caused the death do not enter the mode of dying, such as cardiac or respiratory errest, shock, or hear failure. List only one cause on each line. Approximate Intervel Between Onset and Deeth **Physician** /Medical Metastatic Immediate Cause (Final 3/2 405 Carcinoma disease or condition resulting in deeth) Examiner Due to (or es e conaequence of) Examiner that the death certificate be executed physician and sthe burial-trans Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Lest Due to (or es e consequence of): Physician/Medical Due to (or es e consequence of) 97 65 use ŏ signed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Vohe Khown Division of Vital Records. à 24b. Were eutopsy findings evailable prior to 24e. Wes en eutopsy performed? Completed completion of cause of deeth? 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical exeminer? Be 26. Plece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 2 28e. Dete of Injury (Month, Dey Year) funeral 27. Menper of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? After Certification: 1 Naturel Attending 5 Pending i or Attendin after deeth. Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide Hospitai 24 hours a Funersi C edical 29a. Certifier 10 Certifying Phyelcian: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) end menner es stated. To the Hosp within 24 ho To the Fune completely f (Check only one) 2 Medical Examiner: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signeture and title of certifier 29c. License number 015552 14 1 M.D. 30. Name and address of person who completed clause of death (Item 23e) (Type, Print)

State Registrar 31. Dete filed (Month, Dey, Yeer)

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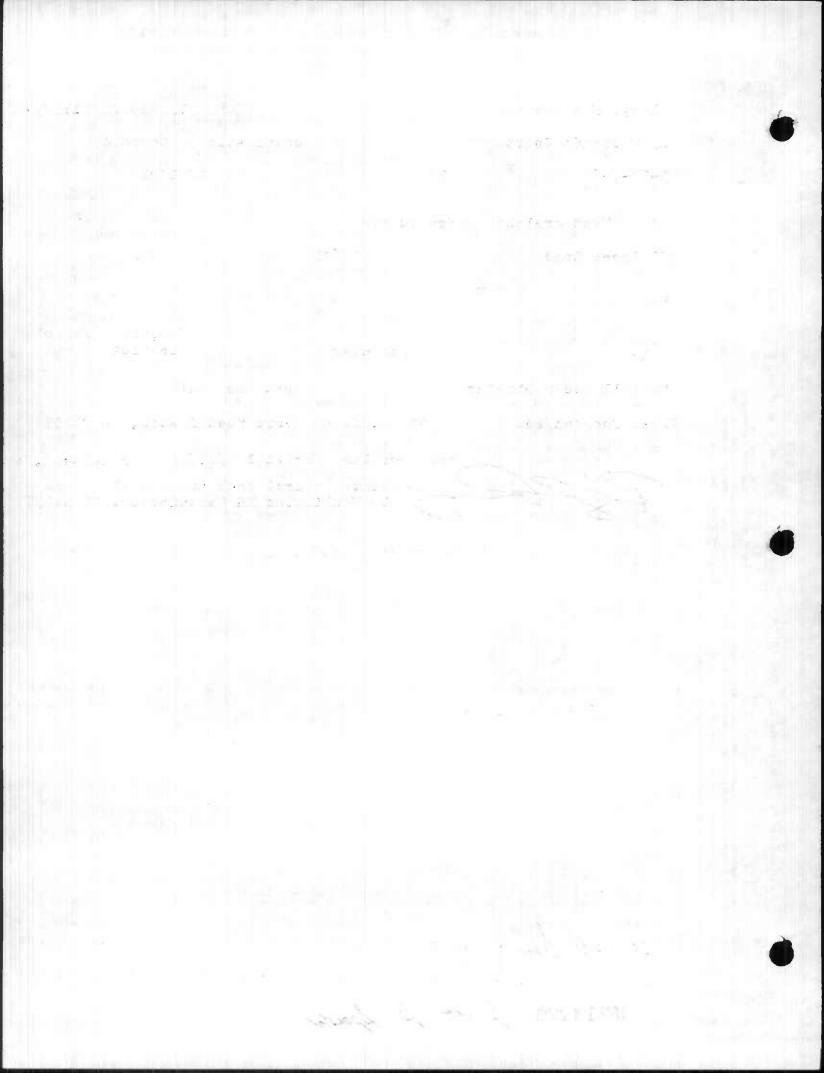
32. Registrer's Signeture

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Washington

Heights

Westminsten Md. 21157



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene \(\cap \) Certificate of Death 2. Date of Death 1. Decedant's Name (First, Middle, Last) 3. Time of Death Year **Physician** Parsons Mildred 7:00Am 2000 anuary /Medical 4a Facility Name (If not Institution, give street end number) 4b. City, Town, or Location of Daath-4c. County of Death Examiner Centreville ionsica Hills Center Genesis Eldercare Queen Hnne | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min | April 27, 1911 5. Social Security Number Birthplace (State or Foreign Country) 7. Aga (In yrs. last birthday) Funeral 89 212-05-1252 Maryland Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f shor traumstic event, the Medical Examinar must be notified at 1 ☐ Yes 2 ☐ No Maryland Queen Anne's Chester 10e Street and Number 10n. Citizen of What Country? 10f. Zip Code 100 Ellicott Drive 21617 IISA Funeral 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Giva Year or Datas: 13. Was Dacedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - Amarican Indian, Black, White, etc. 1 Never Married 2 Married 8 1 Yes XXNo Specify: Baltimore, Maryland 21215-0020 Specify: White by 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) Clerical Insurance 12 17. Father's Nama (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumame) Be Albert William Tiedeman Ida Carrie Brown am si 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Routa Number, City or Town, Stete, Zip Code) Reverend Chuck Braband - Minister 2710 Cecil Dr. Chester, MD 21619 20b. Placa of Disposition (Nema of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 Cramation 3 Removal from Stata Trinity Memorial gardens January 11, 2000 Waldorf. MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fufferal Service Licenses 22. Neme and Address of Facility Fellows, Helfenbein & Newnam Funeral Home plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one church on each line. 23a. Part1. Enter the disease, or complicate shock, or heart feilure. List only one Approximate Intervel Between Onsat and Death **Physician** Premma /Medical Immediate Cause (Final luke disaasa or condition resulting in death) Examiner Due to (or as a consequenca of) Examiner Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated avents rasulting In death) Last Se de Due to (or as a consequenca of) Box 68760 physician Physician/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? P.O. 1 Scree 2 No 3 Probably 4 Unknown Coronar arting disease per phoal vosalor disease 24b. Were autopsy findings evailable prior to completion of cause of deeth? 24e. Wes en autopsy performed? multipliant dementice Completed 1 Tyes 2000 1 ☐ Yes 2 ☐ No this certificate Division of Vital ACCESSED 67 AM 9-9-00 Be 25. Was case referred to medical examinar? 26. Place of Death (Check only one) Othar: 4 Sharsing Home 5 Residence 6 Othar (Specify) P 1 Yes 2500 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mannar of Death 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred 1 Watural 5 Pending Investigation 1 Yes 2 No 2 Accident after death Director: 6 Could not be detarmined 3 Suicide 28e. Place of Injury - At home, farm, straat, factory, office building, atc. (Spacify) 28f. Location (Straet end Number or Rurel Route Number, City or Town, State) 4 Homicide 29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, and due to the cause(s) end manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) and manner stated. Medical 8 To the Within 2 To the 29d. Data signad (Month, Day, Year) 29b. Signature and tille of genifier 29c. Licensa number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2/08 D. Sorah Drin Chester, MU 2/6/9

State Registrar 31. Date filed (Month, Dey, Year) 1 2000

32. Register's Signature

Physeran

Attending

Dr. 500056

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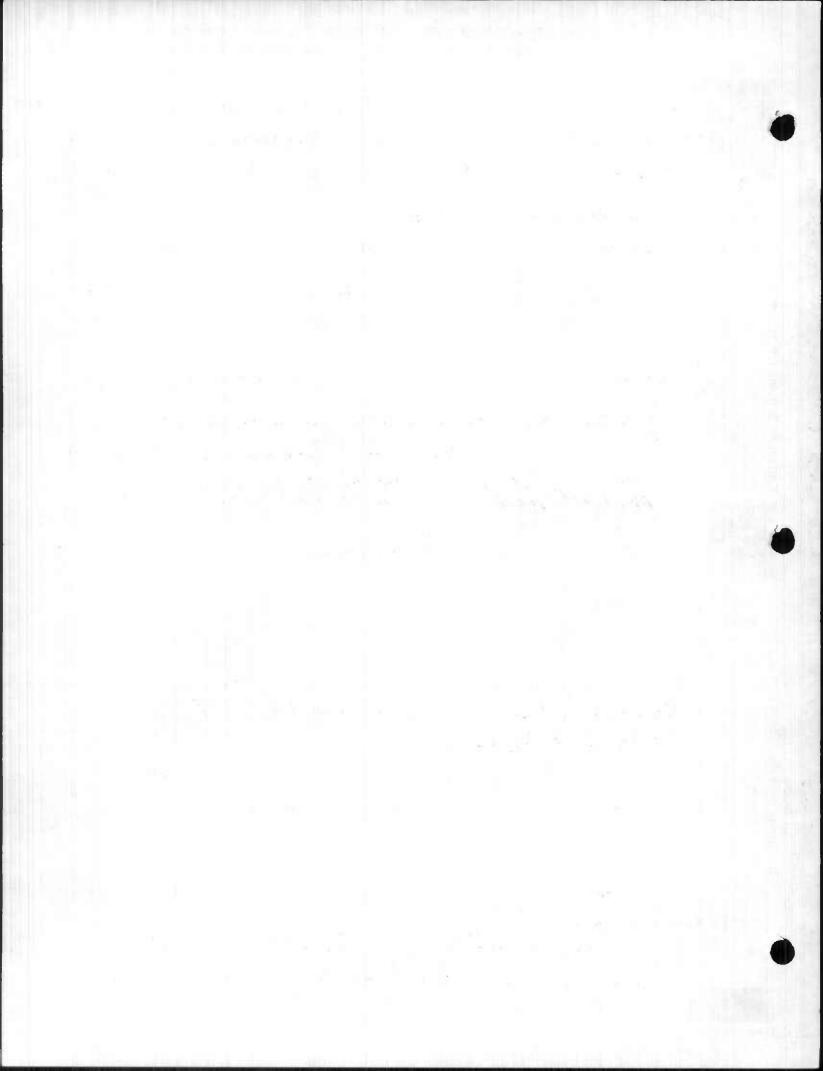
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death Month 3. Time of Death 1. Decedent's Neme (First, Middle, Last) **Physician** CHARLES THOMAS POST **JANUARY** 15, 2000 05:43 AM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Fscility Nama (If not institution, giva street end number) Examiner SACRED HEART HOSPITAL CUMBERLAND If Undar 1 Yaar | If Undar 24 Hrs. 5. Sociel Sacurity Number 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Dey, Year) Birthplaca (Stata or Foreign Country) **Funeral** Days X M 2 F Yes Director 219-44-2436 53 Jul 31, 1946 MD Usual Rasidence of Decedant 10a. Stata 10c. City, Town or Location 10d. Inside City Limits 10b. County r than "natural", or items 23e or 28e-f show the Medical Examiner must be notified at the Maryla 1 Yas 2 □ No Director MD Allegany Cumberland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Coda 238 Humbird Street 21502 Funeral USA 12. Was Decedant Evar in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yas or No If Yas, specify Cuben, Maxican, Puarto Rican, atc.) 14. Race - American Indien, Black, Whita, atc. hours after 1 XYes 2 No If Yas, Give Yeer or Dates: Vietnam Naver Merriad 2 ☐ Married 1 ☐ Yas 2 X No Specify: þ Specify 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedant's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa retired) 15. Decedant's Educetion (Specify only highest grada completed) 16b. Kind of Businass/Industry fled within 72 Elementery/Secondary (0-12) Collega (1-4or 5+) 12 Electrician IEBW #307 of Health and Mental Hygi Hem 27 is marked other 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) ahould be Sheldon Clair Post Grace (Freeland) 19b. Malling Addrass (Straet end Number or Rural Routa Number, City or Town, Steta, Zip Code) 19a. informant's Name/Ralationship (Type, Print) permit. Pages 1 and 2 st Department of Health and Important: If Nem 27 is n Grace Post--mother 238 Humbird Street; Cumberland, MD altimore, 20b. Place of Disposition (Nama of cemetery, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 X Burial 2 Cramation 3 Ramoval from Stata Rocky Gap Veterans Cem 01/17 4 ☐ Donation 5 ☐ Other (Specify) Flintstone, MD 22. Nama and Addrass of Fecility Scarpelli Funeral Home, P.A. 23a. Part. Enter the disease, or compositions that caused the deeth. Do not antar tha mode of dying, such es cerdiac or raspiratory arrast, shock, or heart failure. List only of e ceuse on each line. Approximeta interval Between Onset and Deeth **Physician** /Medical Immadiate Ceuse (Finel disease or condition resulting in deeth) Sepsis 2 weeks Examiner Dua to (or as a consequence of) Examine b. Metastatic Bone Disease Probable unknown ettending physician and for use es the burial-transit The law requires that the death certificata be axecuted Sequantially list conditions, if any, laeding to immadiata ceuse. Entar Underlying Causa (Disaasa or Injury that initieted evants rasulting in death) Last Dua to (or es a consequence of): Box 68760. Physician/Medicai Dua to (or as a consequence of): 80 ed by the deteched 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Hepatic and Metabolic Encephalopathy Records, ò been sig 24b. Wara autopsy findings avellable prior to complation of causa of death? 24e. Was en autopsy parlomad? Completed Splenic Heatoma, Anemia certificate hes b lirector, page 2 s 2 No 1 Yas 1 ☐ Yas 2 ☐ No Division of Vital or Attending Physician: Be 25. Was cesa referred to medical axaminar? 26. Placa of Death (Check only ona) Hospital: Inpatiant Othar: 4 Nursing Homa 5 Residence 6 Othar (Specify) 1 Yes > No P 2 ER/Outpatient 3 DOA this After this 28a. Data of Injury (Month, Dey Year) 27. Menyar of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Panding Invastigation 1 Yas 2 No To the Hospital or Attendit within 24 hours efter death.
To the Funeral Director: A completely filled in by the fu death. 2 Accidant 6 Could not be determined 3 Suicida 281. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 4 D Homicida edicai 29a. Certifiar DECertifying Physician: To the best of my knowledge, daath occurred at tha tima, data and place, and dua to tha causa(s) and manner es steted. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete end place, and due to the cause(s) end manner stated. (Check only one) 2 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Dev. Year) 6 30. Nama and address of parson who complated ceusa of daath (Itam 23a) (Type, Print) D96907 January 15, 2000

State

State Registrar

Harjit Sidhu, M.D.; 925 Bishop Walsh Road; Cumberland, MD 21502

31. Data Hed (Month, Day, Year)

JAN 1 8 2000

32. Registrar's Signatura



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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent'e Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Physician Powell Albert Luther 14, 2000 1644 January /Medical 4c. County of Daath
Allegany 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Cumberland Sacred Heart Hospital Hours Min. 8. Date of Birth Octon Bay, Year 9 18 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) Birthplace (Stete or Foreign Courting) **Funeral** Months Days 11 M 2□ F Hours 81 705-05-4811 Director Usual Residence of Decedent the Maryland 10s. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 X Yes 2 □ No Cumberland Director MD Allegany 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 21502 USA 1108 LaFayette Avenue then "natural", or flams 23s Funeral 12. Was Decedent Ever in U,S. Armed Forces?

1 ☐ Yes 2 ☐ No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - Amarican Indien, Black, White, etc. filed within 72 hours after Hygiene. ther then "natural", or its 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: white à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) Retired Machinist B & O Railroad permit. Pages 1 and 2 ahoud be filed w Department of Heath and Mental Hygien Important; if less 27 is marked other tha any injury or other theumatic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) (Beal) Elizabeth V Earl Leo Powell 19b. Maijing Address (Street and Number or Rural Route Number, City of Town, State, Zig Code 2 1502 19a. Informant's Name/Relationship (Type, Print)
Gertrude Powell 20a. Method of Disposition 20b. Place of Disposition (Name of cemetary, crematory or other place) Date 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Restlawn Memorial Gard1/17/ LaVale, MD 21. Signature of Funeral Service Licenses 22Strambedestifo Muneral Home P.A. Cumberland, Maryland 21502 death. Do not enter the mode of dying, such as cardiac or respiratory errest, 23a. Part 1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each Approximata Interval Between Onset and Death **Physician** hemombeg /Medical Immediata Cause (Final disease or condition resulting in death) ntracereband Examiner Physician/Medical Examine attending physician and for use as the burtal-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Due to (or as a consequence of): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yee 2 No 3 Probably 4 Unknown Records, à 24b. Wera eutopsy findings evailable prior to completion of cause of death? should 24a. Was an autopsy performed? Completed 1 Yas 2 No 1 ☐ Yes 2 ☐ No certificata Division of Vital Be 25. Wes case referred to medical axaminer? 26. Place of Daath (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 10 Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred After t or Attanding 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No Director: / 2 Accident To the Hospital or Attar within 24 hours after dea To the Funeral Director completely filled in by th 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the tima, date and place, and due to the cause(s) and manner es stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the tima, data and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier D36766 January () 2000 30. Name and address of person who comof death (Item 23a) (Type, Print) eteo cau Highway LaVale MD 21502 nds. Youna, National 22. Registrar's Signature State Registrar

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2000 10:40am January 6 Jr. Patterson /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Caroline Nursing Home, Inc. Denton Caroline If Under 1 Year | If Under 24 Hrs 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days Months Hours 1 M M 2□ F Director 215-09-0538 86 Mar. 7, 1913 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 25a-f show The Maryla 1. Yes 2 No Directo Maryland Caroline Greensboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? à must be 115 Park Ave. 21639 "naturel", or harns 23a USA Funeral 11. Maritel Stetus 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces 1 12 Yes 2 No If Yes, Give Year or Dates: 1/42 - 10/45 Black, White, etc. 72 hours after 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Black Completed 16e. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) 6 Janitor Pet Milk Pages 1 and 2 should be filed in nent of Health and Mental Hygis ant. If Nem 27 is marked other I 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Guy G. Patterson, Sr. Leona Black 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Neme/Relationship (Type, Print) Department of Health as Important: If item 27 is any injury or other trau Shirley Thompson, Niece P.O.Box 143, Greensboro, Maryland 21639 20b. Ptace of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stata 1 Burial 2 □ Cremetion 3 □ Removel from State OKERS Cemetery Greensbor, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 1-13-2000 21. Signature of Funeral Sandas Licenses 22. Name and Address of Facility Bennie Smith Funeral Home P.O.Box 1687, Easton, Maryland 21601 23a. Part I. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximate Intervet Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition rasulting in death) Examiner diabetes mellitus years Examiner insulin physician and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequenca of): Box 68760 Physician/Medical Due to (or as a consequence of): 52 080 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? certificate has 1 Yes 2 No 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific Be 25. Was case referred to medical exeminer? 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 2 No After thi funeral 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27, Menner of Death 28b. Time of 28c. Injury at Work? Certification: 5 Panding investigation 1 Natural 1 Yes 2 No 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Placa of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29e. Certifier edical 📆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D00475 00 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 16 Rev 6/95

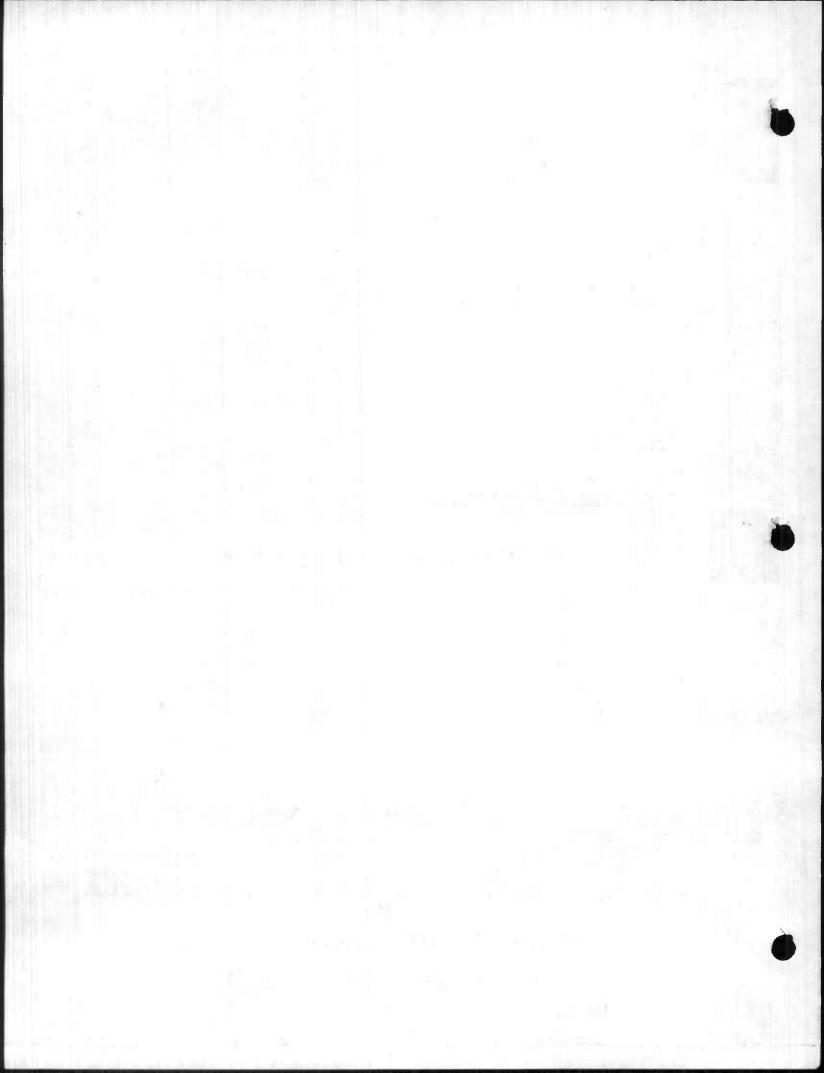
State

Registrar

31. Date fited (Month, Day, Year)

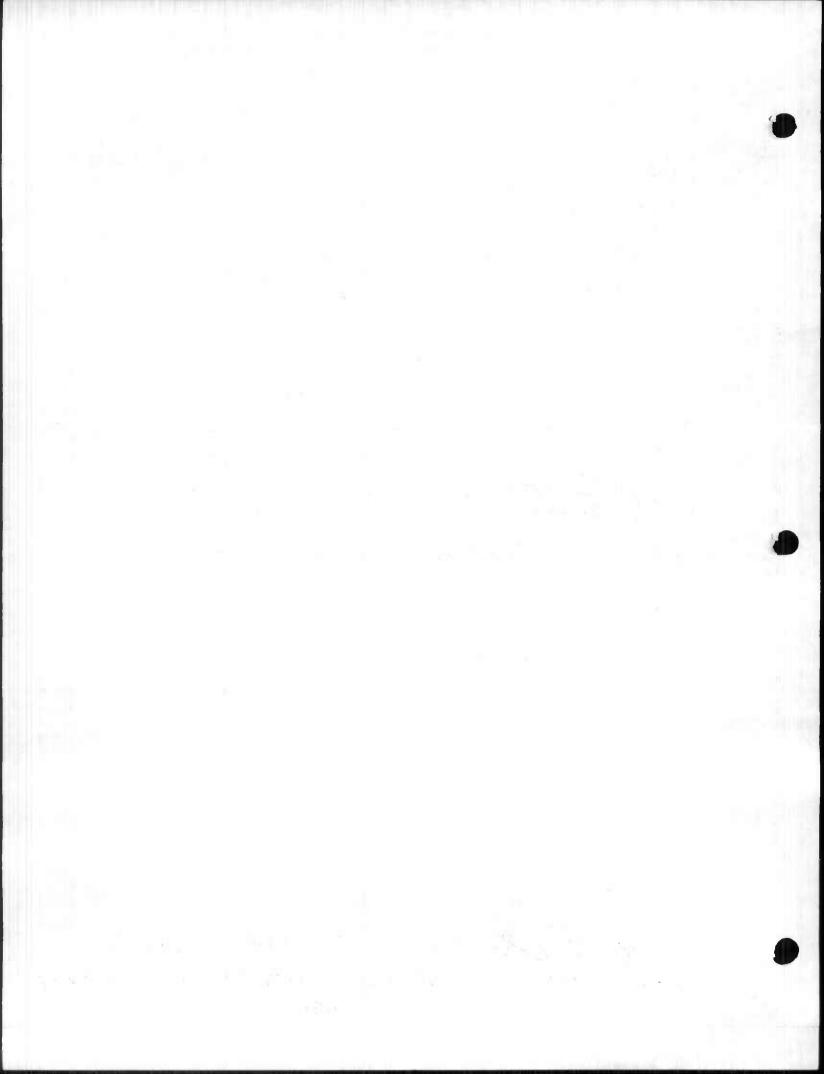
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32. Registrer's Signature



State of Maryland / Department of Health and Mental Hygiene

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|------------|--|-------------------|---|--|-------------------|-----------------------------------|-------------------------|---|-----------------------------------|----------------|---------------------------|--|
| | Dhusis | | 1. Decedent's Name (First, Middle, Las | t) | | | | | 2. Dete of Dee Month | | Year | 3. Time of Death |
| | Physici /Medi | | Henrietta | R. P | ierce | | | | January | | | 5:00 AM |
| | Examir | | 4e. Facility Neme (If not institution, giva | street and number) | | | - | 4b. City, Town, or | | | | |
| | | | Shore Nursing & | Rehabili | tation | Center | | Dentor | 1 | C | arolin | e . |
| | Funeral | | 5. Social Security Number 6. Se | 7. Ag | e (In yrs. lest i | birthdey) If Un Monti | der 1 Year ns Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Dey | Year) | 9. Birthpled | ca (Stete or Foreign |
| ١. | Director | | 253-42-8282 | 7 IAI 5761 | 83 | Yrs. | | | May 26 | | | |
| | pue ** | | Usuel Residence of Decedent 10a. Stete 10b. County | | 10c. City, To | wn or Location | | | | | 10d | I. Inside City Limits |
| | Maryl f sho | ō | Maryland Talbot | | Co | rdova | | | | | | 1 Yas 2 No |
| | 158 158 158 158 158 158 158 158 158 158 | rect | 10e. Street and Number | | | | Zip Code | | | 0g. Citizen of | What Country | n |
| | 3a or | O | 11419 Kitty's Co | rner Road | | | 21625 | | | USA | , | |
| | ter death with the Marylen items 23a or 28a-f show iner mant be notified at | Funeral Director | 11. Marital Status | 12. Was Decedent I | | | | lispanic Origin? (S an, Maxican, Puart | pecify Yas or No- | 14. Rad | ce - Amarican | |
| 0 | 72 hours efter death with the Maryland natural', or items 23a or 28s-f show dinal Examinet must be notified at | | 1 Never Married 2 Married | Armed Forcas? 1 ☐ Yes 2 📉 | ło | | | | o Rican, etc.) | | ck, Whita, etc | <i>t.</i> |
| 02 | n 72 hours efte "natural", or i | l by | 3 ☐ Widowed 4 ☐ Divorced | If Yes, Give Year or Dates: | | ILI Yes | 2 PU NO | Specify: | | Specif | Blac | k |
| 5 | 72 h | Completed | 15. Decedent's Edu (Specify only highest gred | | 16 | Sa. Decedent's U (Give kind of | sual Occup work done | petion during most of word) | king | 16b. Kind of B | usiness/Indus | stry |
| 21215-0020 | within ane. than " | шb | Elementary/Secondary (0-12) | College (1-4or 5 | +) | | | d) | | | | |
| 7 | e filed within al Hygiane. I other than vent, the We | ပိ | 17. Father's Neme (First, Middle, Last) | | | Line Wor | rker | 10 Mathada Nor | ne (First, Middle, | | en Foo | d |
| au | d of other | Be | | | | | | | ne (First, Middle, | welden Sumer | ne) | |
| Maryland | should b nd Mante marked umartic e | To | Saul 19a. Informant's Name/Relationship (T) | rog | | Oh Mailing Adds | ana (Ctront | Pauline and Number or Ru | uni Barda Mumba | City or Town | Will: | |
| S S | d 2 shouth end the end traum | | | | | | | | | | | |
| | ges 1 and 2 should be filed within 72 hc to Health and Mantal Hygiane. If itam 27 is marked other than "natur or other traumatic event, the Medical | | Henry Pierce, Hub 20e. Method of Disposition | and | 20b. Place | of Disposition (| Verne of | s Corner | Rd., Cor | dova, | Marylan - City or Town | nd 21625 n. Stata |
| Baltimore, | Pages nent of int: If its iry or o | | 1 ☑ Burial 2 ☐ Cremetion 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) | | Come | tery, cremetory | ou ourer pre | s Cem. | | | | |
| | 그 된 큰 중 | | 21. Signeture of Funeral Conce Licans | | rial y | | | ess of Facility | ./10/00 | Beulah | , Mary L | and |
| B | Deperiment of the series of th | 0 3 | | _ | | | | 4 . 1 | ral Home | | | |
| | | | 23a. Part1. Entar the disease, or comp shock, or heert failure. List only o | lications that caused | the deeth. D | P.O. | Box | 1687, Eas | ton, Mary | land 2 | 1601 A | nnroximate |
| 15 | Physician | | shock, or heert failure. List only o | ne ceuse on eech lir | 10. | | , | | | | ln O | pproximate itervat Between insat and Death |
| 5 | /Medical | | tmmediate Ceuse (Finat disaese or condition | Mot | note | His | ner | Vical | CAN | innin | 101 | IOV |
| | Examiner | | resulting in death) | a. ///// | | e consequence | | VICCU | Curc | CILOVI | 4 | 10/ |
| | D 55 | ner | | | 200 10 (0. 00 | | ,. | | | | | |
| | tificata be axecuted ig physicien and as the bunal-transit | Examiner | Sequentially list conditions, | b | Due to (or as | a consequenca | of): | | | | | |
| ŠĆ, | se axe | <u> </u> | Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events | 0 | | | | | | | | |
| 68760, | physic the b | Physician/Medical | thet initiated events resulting in deeth) Lest | C | Due to (or as | e consequence o | of): | | | | | |
| | | Me | | d | | | | | | | | |
| Box | that the death car ed by the attendir datached for use | clan | | | | | | | | | | |
| P.O. | the d | iysi | Part II. Other significent conditions con | ntributing to death bu | it not resulting | In the underlyin | g causa giv | en In Part i. | | 10 | | ne cause of death? |
| | that led by data | | | _ | | | | | 1 🗆 Y | es 2 XNo | 3 Probab | bly 4 Unknown |
| Records, | w requires that the s been signed by the should be datache | d by | | | | | | | 24a. Was a | n autopsy | 24b. Were | autopsy findings |
| O O | - Ad 67 | lete | | | | | | | perfor | | comp | abla prior to pletion of cause |
| He G | has be | Completed | | | | | | | 400 | aless. | of dea | |
| Vital | | | 25. Wes case referred to medical | | | _ | | oc Disease Day | 1 U Y | | 1 🗆 Y | res 2□ No |
| 5 | | To Be | examiner? | Hospitel: | nt 2 DER# | Outpatient 3 | DOA Oth | or a | ome 5 Resident | | os (Cassiés) | |
| Ö | Phys eral di | | 27. Mapger of Deeth | 28e. Date of Injur | y 28b | . Time of | 28c. Injui | ry at | 28d. Describe h | | | |
| 0 | Attending ir death. ector: After by the fune | atlo | 1 Neturel 5 ☐ Pending investigation | (Month, De) | Year) | Injury M | 1 🗆 | Yes 2 □ No | | | | |
| DIVISION | or Attending Phy aftar death. Director: After thi d in by the funeral | Certification: | 3 Sulcida 6 Could not be determined | 28e. Placa of Injubuilding, etc | ry - At home, | farm, street, fec | tory, office | | 28f. Location (Si City or Town | reet end Numi | per or Rural R | loute Number, |
| 5 | rs after or all Oir | Ce | | ounding, etc | . (Opecity) | | | | Ony or Town | 1, 31616) | | |
| | To the Hospital or Att within 24 hours after of To the Funeral Direct completaly filled in by | edical | 29a. Certifier Certifying Phy. | sician: To the best of ner: On the basis of | f my knowled | ge, deeth occurr | ed at the til | me, dete end plece | , end due to the c | euse(s) end me | enner es stete | ed. |
| | the Hin 24 | Med | | and menner sta | ted. | | | | | | | |
| | 7 wit | | 29b. Signature and title of certifier | /no. | | | zec. Licens | e numbar | 1. | 9d. Date sione | a (Month, De | y, Year) |
| | | | / Marth | all | MO | | 0 | 50 000 | | 1/11 | 100 | |
| | | | 30. Name and address of person who co | ompleted cause of de | eath (Item 23a | (Type, Print) | 1100 | hington | C+ B | Taph | | 21101 |
| | | | 31. Dete filed (Month, Day, Yeer) | 30 Bodister | r's Signature | 1 3.0 | JUSI | ingion | 31 8 | astor | mi. | 11001 |
| | Sta Registr | - 1 | IAN 1 4 20 | nn Den | 2 Julian | D. 1 | pour | 2 | | | | |



| Physician | 1000 | nt's Name (First, M | fiddla, Last, |) | ER MEO | | | | | | 2. Dete of D Month | Day | | Year | 3. Tima of Dea |
|---|--|---|--|---|--|--|--|------------------|--|--|--|---|--|--|--|
| /Medical | | BERT E. F | | | 1 | | | | 4h Cihi To | um orla | Janua | nds. | | 000 | 10:41 7 |
| Examiner | 48 Fecility | Neme (If not instit | _ | | - | | | | Lanhar | | OCATION OF LIGH | | , | of Death Ce Ge | orges |
| uneral | 5. Social S | Security Number | 6. Sa | | . Aga (In yrs. | last birthdey) | If Under | r 1 Yaar Deys | If Under Hours | 24 Hrs. Min. | 8. Dete of E (Month, L | | | | laca (State or For |
| irector | | 1-3777 | | M 2□ F | | Yrs. | 2 | 1 | 1,00.0 | | Novembe | | 999 | | ngton,D.C. |
| ahow sdat | 10a. State | | | | 10c. Cit | y, Town or Lo | ocation | | | | 10d. Insida City Limit | | | | |
| 28a-1 a | D.C. | | | | Wash | ington, | D.C. | | | 1 Yas 2 D | | | | | |
| D 20 | 10e. Stree 808 A | t and Number Labarra Aven | ir. S. | E. | | | 10f. Zip | | | | 10g. Citizen of What Country? | | | | try? |
| The 23a | 11. Marital | | | 12. Was Deced | ant Evar In U | ,S. 13. | Was Deced | dant of H | lispanic Ori | gin? (Sp | ecify Yas or N | | | e - Amaric | |
| by by | 3 □ w | ovar Merried 2 | | Armed Ford 1 Tas 2 If Yas, Giva Yeer or Dat | ₽ No | | 1 □ Yas | | Specify: | i, Puarto | Rican, atc.) | | | k, White, Blac | |
| nt, me Medical | TIE | 15. Dece (Specify only hi | dant's Edu | | 100 | 16e. Dece | 6e. Decedant's Usual Occupation (Giva kind of work dona during most of work life. DO NOT use retired) | | | t of work | 16b. Kind | | | usinass/Inc | dustry |
| than omple | Element | tary/Secondery (0-1 | 12) | College (1-4 | lor 5+) | | Worker | | d) | | | n/= | | | |
| 2 0 | 17. Fathar | 's Nema <i>(First, Mid</i> | dia, Last) | | | | | | ır's Nam | n/a Name (First, Middla, Maidan Sumama) | | | | | |
| | | E. Janes | | | | | | | Carli | sa R. | Pearson | 1 | | | |
| E | 19a. Infon | mant's Name/Ralet | ionship (Ty | pe, Print) | | 19b. Maili | ng Addrass | s (Straat | end Numbe | er or Run | al Routa Num | ber, City o | r Town, | Stata, Zip | Coda) |
| om 2 other | | a R. Pearson od of Disposition | n/Moth | er | 20b. F | Place of Dispo | sition (Nan | ma of | | shing | ton, D.C | | | City or To | wn, Stata |
| | 15B 41D | urial 2 Cramationation 5 Otha | ion 3 □R | temovel from Si | ata | amatary, crar | | | ca) | 1 | /19/00 | Suitl | 227 | MO | |
| Important: Pany Injury o | 21. Signeture of Funeral Service Licensee 1 1 22. Name and Address of Facility CEDAR HIII | | | | | | | | | | | | | TNC | |
| ESS | All Pennsylvania Ave., Suitland, MD 20746 23a. Part Filter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one pause on each line. | | | | | | | | | | | | | nc. | |
| edical | disaasa o | a Causa (Final r condition | | | | ANT DE | | | | | | arrast, | | | Approximeta Interval Between Onsat and Daati |
| Hransit xaminer | disaasa or rasulting ii | r condition n death) | (| | EN INF | | ATH S' | YNDR | | | | anast, | | | Interval Between |
| he burial-transit | Sequentia if any, laa cause. Er Cause (Di that initial in a suiting in | r condition n death) ally list conditions, ding to immediate tar Underlying seese or Injury | { | | Dua to (c | ANT DE | ATH S' quanca of): quanca of): | YNDR | | | | allast, | | | Interval Between |
| he burial-transit | Sequentia if any, laa cause. Er Cause (Di that initial in a suiting in | r condition n death) ally list conditions, ding to immediate ntar Underlying seese or Injury see events | { | SUDDI | Dua to (c | ANT DE or as a consactor as a consac | ATH S'quanca of): | YNDR | ROME (| SIDS | 5) | | use cor | ntribute to | Interval Between |
| he burial-transit | Sequentia if any, laa cause. Er Cause (Di that initial in a suiting in | r condition n death) tilly list conditions, ding to immediate later Underlying seese or Injury ed events n death) Last | { | SUDDI | Dua to (c | ANT DE or as a consactor as a consac | ATH S'quanca of): | YNDR | ROME (| SIDS | 23b. DI | d tobacco | | | triterval Betweer Onsat and Daatt |
| over signed by the attending physician and include be detached for use as the burlal-transit and by Physician/Medical Examiner | Sequentia if any, laa cause. Er Cause (Di that initial in a suiting in | r condition n death) tilly list conditions, ding to immediate later Underlying seese or Injury ed events n death) Last | { | SUDDI | Dua to (c | ANT DE or as a consactor as a consac | ATH S'quanca of): | YNDR | ROME (| SIDS | 23b. Di | d tobacco | ⊠ No | 3 ☐ Prol | triterval Betweer Onsat and Daatt |
| page 2 should be detached for use as the burial-transit and page 2 should be detached for use as the burial-transit and completed by Physician/Medical Examiner | Sequentia if any, lear cause. Er Cause (Di that initiat rasulting in | r condition n death) ally list conditions, ding to immediate thar Underlying seese or Injury ad events n death) Last | dittone con | SUDDI | Dua to (c | ANT DE or as a consactor as a consac | ATH S'quanca of): | YNDR | ROME (| SIDS | 23b. Di 1[24a. Wa | d tobacco ☐ Yes 2. | ⊠ No esy | 3 Prol | o the cause of de bebly 4 Unk |
| certificate has been signed by the attending physician and riector, page 2 should be detached for use as the burial-transit and Be Completed by Physician/Medical Examiner | Sequentia if any, lear cause. Er Cause Er Cause In that initiate rasulting in Part II. Oth | r condition in death) fully list conditions, ding to immediate that Underlying seese or Injury ed events in death) Last | dittone con | SUDDI | Due to (c | ANT DE | ATH S'quanca of): quanca of): quance of): | YNDR | come (| SIDS | 23b. Di 1[24a. Wa per | d tobacco Yes 2. as an autopromed? Yas 2(Young) | No No | 3 ☐ Prof 24b. Wi ev co of | o the cause of de bebly 4 Unk ere autopsy findir ailable prior to mpletion of cause daath? |
| his certificate has been signed by the attending physician and sidector, page 2 should be detached for use as the burlal-transit. To Be Completed by Physician/Medical Examiner. | Sequential any, lead cause. Errouse (Dithat initiate rasulting in Part II. Oth | asa rafarred to mediate see 2 No r of Death stural 5 Pe | dittone conditional | SUDDI | Due to (o | ANT DE or as a consactor as a consac | ATH S'quanca of): quanca of): | YNDR | 26. Place | SIDS | 23b. Di 1[24a. Wa | d tobacco Ves 2. as an autor formed? Yas 2(y ona) | No No | 3 Prof | o the cause of de bebly 4 Unk ere autopsy findir ailable prior to mpletion of cause daath? |
| After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the buris-transit and funeral director. Page 2 should be detached for use as the buris-transit | Sequentia if any, lead cause. Er Cause (Di that initiate rasulting in Market 11. Oth 125. Wes caxamir MENTE 27. Manna 1 Market 27. Manna 2 A 3 S 1 | asa referred to mediate as a referred to mediate. | dittone con | dospital: 1 In In 28a. Date of (Month.) | Due to (or | or as a consector as | ATH S' quanca of): quanca of): quance of): quance of): quanca of): | YNDR | 26. Place | SIDS | 23b. DI 1[24a. Wa pe 1,5 th (Check only oma 5 □ Ra 28d. Dascrib | d tobacco Yes 2, as an autopromed? Yas 2(y ona) sidanca e how injur | No No Osy No Othery occurred Number | 3 Prol 24b. We even of 1 J. ar (Specifited | o the cause of de bebly 4 Unk ere autopsy findir ailable prior to mpletion of cause daath? |
| After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the buris-transit and funeral director. Page 2 should be detached for use as the buris-transit | Sequentia if any, lead cause. Er Cause (Di that initiate rasulting in Market 11. Oth 125. Wes caxamir MENTE 27. Manna 1 Market 27. Manna 2 A 3 S 1 | asa referred to meres 2 No r of Death tural 5 Pe cident inv tural 5 Pe cident inv tuicide 6 Co omicide 1 Cent k only 12273Medi | dittone conditions and indicate the conditions are stigation and individual and indicate the conditions are stigation and indicate the conditions are stigation and indicate the conditions are stigations are stigation | dospital: 1 In In 28a. Date of (Month.) | Due to (or Due to | or as a consector as | ATH S'quanca of): quanca of): | YNDR: | 26. Place 26. Place ar: 4 Nu y at k? Yas 2 | SIDS | 23b. Di 1[24a. Wa per 15 28d. Dascrib 28f. Location City or 7 | d tobacco Yes 2. as an autor fromed? Yas 2! y ona) sidanca e how injur (Street en own, Stete | No No Other | 3 Prol 24b. Wi eve co of 1 par (Specified | thierval Betweer Onsat and Daatt on the cause of de bebly 4 Unk ere autopsy findir ailable prior to mpletion of cause death? |
| ther this certificate has been signed by the attending physician and inner director, page 2 should be detached for use as the burial-transit on: To Be Completed by Physician/Medical Examiner | Sequential if any, laat cause. Er Cause Uting in the cause of the caus | asa referred to meres 2 No r of Death tural 5 Pe cident inv tural 5 Pe cident inv tuicide 6 Co omicide 1 Cent k only 12273Medi | dittone conditions display the state of the | dospital: 1 In | Due to (or Due to | or as a consector as | ATH S' quanca of): | YNDR: | 26. Place van In Part I 26. Place har: 4 Nu y at k? Yas 2 U | SIDS | 23b. Di 1[24a. Wa per 15 28d. Dascrib 28f. Location City or 7 | d tobacco Yes 2, as an autopromed? Yas 2(y ona) sidanca e how injur (Street en own, Stete e cause(s) a, dete and | No 3 Prol 24b. We eve of of 1 process of 1 proc | o the cause of de bebly 4 Unk ere autopsy findir ailable prior to mpletion of cause death? A Yas 2 No No Transport No Tr |
| After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the buris-transit and funeral director. Page 2 should be detached for use as the buris-transit | Sequential any, laad cause. Er Cause (Dithat initial rasulting in the cause) of the cause (Dithat initial rasulting in the cause) of the cause (Dithat initial rasulting in the cause) of the cause (Dithat initial rasulting in the cause) of the cause (Cause) of the cause (Checone) | asa rafarred to mer algoritural 5 Pecident invuicide 6 Coomicida | dittone conditions and the conditions and the conditions are the conditions and the conditions are the condi | dospital: 1 In In 28a. Date of (Month, 28e. Plece of building and mannar and | Due to (o Ath but not ras Destiant XXX Injury Day Year) If tnjury - At hat, atc. (Specification of axaminar of axam | or as a consector as | ATH S' quanca of): | YNDR: | 26. Place van In Part I 26. Place har: 4 Nu y at k? Yas 2 U | SIDS | 23b. Di 1[24a. Wa per 15 28d. Dascrib 28f. Location City or 7 | d tobacco Yes 2, as an autopromed? Yas 2(y ona) sidanca e how injur (Street en own, Stete e cause(s) a, dete and | No 24b. We ever of a series of a | o the cause of de bebly 4 Unk ere autopsy findir ailable prior to mpletion of cause death? A Yas 2 No No Transport No Tr |

DHMH 16 Rev 6/95

ORIGINAL

0005 1 8 MAI.

| - | Decedent's Name (First, Middle, L. | nst) | Oen | ificate of | Journ | 2. Date of De | Reg. No. | 3. Tima of D | eath | | |
|------------------------|---|---|---------------------------------------|--|--|--|--------------------------------------|--|---------|--|--|
| cian | THERMAN L. | | | | | Month | Day | Year 5.4 | 500 | | |
| edical | 4a Facility Name (If not Institution, gi | | | | 4b. City. Town, o | or Location of Deat | h 4c. County | of Death | J you | | |
| miner | SOUTHERN MARYLAN | | | | Clinton | | | George's | | | |
| eral | | | s. last birthday) | If Under 1 Year | If Under 24 H | rs. 8. Date of Bir | th | Birthplace (State or I Country) | Foreign | | |
| tor | 227-32-7583 Usual Residence of Decedent | 18 M 2□ F 70 | Yrs. | Months Days | Hours Mi | n. (Month, Da August | 1,1929 | Virginia | | | |
| 9 . | 10a. State 10b. County | 10c. C | City, Town or Loca | ation | | | 10d. Inside City Limit | | | | |
| Director | Maryland Prince (| George's Di | strict E | | | | 1 Yes 2 □ No | | | | |
| 777 | 10e. Street and Number 1410 Fairfield Di | rive | | 10f. Zip Code 2074 | .7 | 7.6 | 10g. Citizen of What Country? USA | | | | |
| Funeral | 11. Marital Status | 12. Was Decedent Ever in I | U,S. 13. W | as Decedent of | Hispanic Origin? | spanic Origin? (Specify Yes or No- 14. Race - American Indian, | | | | | |
| by | 1 Never Married 2 Married 3 Widowed | Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: WWII | | Yes, specify Cut | | erto Rican, etc.) | Specify: Black | | | | |
| eted | 15. Decedant's E (Specify only highest gi | | 16a. Decede | nt's Usual Occu | pation during most of w | rorking | 16b. Kind of Bu | siness/Industry | | | |
| Completed | Elementary/Secondary (0-12) | College (1-4or 5+) | | o NOT use retire aborer | during most of working ad) | | Private | Industry | | | |
| | 17. Fether's Name (First, Middle, Las | ") | 130 | DOLCI | 18. Mother's N | ama (First, Middle | | | | | |
| o Be | George Price | | | | Helen | Pettawa | y | | | | |
| - | 19a. Informant's Name/Relationship | (Type, Print) | 19b. Mailing | Addrass (Stree | t and Number or | Rural Routa Numb | er, City or Town, | Stata, Zip Code) | | | |
| | Charles C. Price | | | | d Drive | Distric | t Height | s.Md.20747 | | | |
| 5 | 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 (| | Place of Disposi cemetery, creme | tion (Name of story or other ple | oce) | 1/19700 | 20c. Location - | City or Town, State | | | |
| | 4 Donation 5 Other (Special | (y) Qu | antico N | lational | Cemeter | ту | Quantico | ,Virginia | | | |
| sician | 21. Signature of Funerel Service Lice | naee | | 14-17 | | | | | | | |
| | WY | Jeffen | | | | Home, In | | 001 | | | |
| | 23a, Part1. Enter the disease, or conshock, or heart lailure. List ann | one cause on each line. | th. Do not enter | tha mode of dy | ing, such as card | ac or respiratory a | rrest, | Approximata Interval Betwe | en | | |
| | | 8 | | | | | | Onset and De | | | |
| al er | Immediate Cause (Final disease or condition resulting in death) | ndition 3 C/33/3 | | | | | | 2-30 | ay | | |
| | resulting in death) | Dua to | (or as a conseque | ence of): | | | | 1 | 0 | | |
| Examiner | Comments the time and divisor. | b | for an a conseque | 2000 cO: | | | | | | | |
| | Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or injury | Due to (or as a consequence of): | | | | | | | | | |
| edicai | Cause (Disease or injury that initiated events resulting in death) Last | c. Due to (| or as a conseque | ence of): | | | | | | | |
| ~ | resulting in coatti) Last | d | | | | | | | | | |
| Physician | Part II. Other significant conditions | contributing to death but not re | sulting In the und | lertvina cause gi | ven in Part I. | 23b. Did | tobacco use cor | tribute to the cause of | death? | | |
| h, | | | | | | 10 | 3 Probably 4 € 0 | , nknown | | | |
| by | Diabetes | | | | | | | | | | |
| Completed by P | COPD. | | | | | | an autopsy ormed? | 24b. Wera autopsy line available prior to | | | |
| ple | | | | | | | | completion of cau of death? | JSO | | |
| Com | Peripheral V | asular disu | are | | | 10 | Yes 25 No | 1 ☐ Yes 2 ☐ 1 | 6 | | |
| Be | 25. Was casa referred to medical axaminar? | 11 | , | | | eath (Check only | one) | | | | |
| 2 | 1 ☐ Yes 2 ☑ No | Hospital: 1 ☐ Inpatient 2 ☐ | 1 | 3LI DUA | | Home 5 ☐ Resi | | | | | |
| 0 | 27. Manner of Death 1 ☑Natural 5 ☐ Pending | 28a. Date of Injury (Month, Dey Year) | 28b. Tima of Injury | | ork? | 28d. Describe | how injury occurr | ed | | | |
| cat | 2 Accident investigation 3 Suicide 6 Could not t | | | | Yas 2 No | | | | | | |
| Certification: | 4 Homicide determined | | homa, farm, stree ify) | et, lactory, office | | 28f. Location (City or To | | er or Rural Route Numbe | 9r, | | |
| Medical Certification: | 29a. Certifier (Check only one) 1 Certifying Pl | nysician: To the best of my kninner: On the basis of examinand manner stated. | owledge, death o ation and/or inve | occurred at the li stigation, in my | ime, data and pla opinion, death oc | ce, and dua to tha curred et the time, | cause(s) and ma date end place, a | nner as stated. and due to the cause(s) | | | |
| × | 29b. Signature and title of certilier | | | 29c. Licen | se number | | 29d. Date signed | (Month, Day, Year) | | | |
| \neg | Roistan Fa | - alistur | | D | 43446 | | 1.12. | 00 | | | |
| / | 30. Name and address of person who | | | | | Suite | 01 (1) | nton, MD 20 | 777 | | |
| | ROINTAN FARA | | | OLD B- | ranch Av | e C-1 | | 7.04,100 | 733 | | |
| | 31. Date filed (Month, Day, Year) | 32. Registrar's Sign | ature | | | | | | | | |
| State istrar | JAN 1 4 2000 | | | boards | | | | | | | |

DHMH 16 Rev 6/95

0005 : I WAL

| | | | | | arylar | | | | Death | i Mentai Hy | Reg. No. | 02353 | |
|-------------|---|--|--|--|-----------------------------|--|-----------------|---|---|---|-------------------------------------|--|------------|
| Ş | Physici /Medic | _ | | A MAE PLEA | | | | | | 2. Data of D Month Jan Ma | ry Day | 2000 (0 10) | n |
| | Examin | er | 4a Facility Nama (If not institution, gi DOCTOR'S HOSPITA | | | | | | 4b. City, Town, o | or Location of Dea | PRINCE GEORGE'S | | |
| | Funeral Director | | 284-24-9540 | Sex 1 □ M 2 1 F | 72 | last birthday) Yrs. | If Und Month | er 1 Year Days | if Under 24 H Hours M | in (Month C | irth (1927) 14,1927 | 9. Birthplace (Stata or For RENDVILLE, OH | eign IO |
| Mandand | a or 28a-f show be notfred at | tor | Usual Rasidance of Decedant 10a. Stete 10b. County MARYLAND PRINCE | GEORGE S | | ty, Town or Loc OWIE | ation | F | | | - | 10d. Inside City Lii | |
| with the | 23a or 28u | i Director | 10e. Street and Number 16010 EXCALIBUR | RD. #402 | RD. #402 20716 | | | | | 10-46 | 10g. Citizen of 1 | What Country? | |
| OOZO | il', or home 2 | by Funeral | 11. Merital Status 1 Never Merried 2 Merried 3 Widowed 4 X Divorced | 12. Was Decedant Armed Forcas? 1 Yas 27 If Yas, Giva Yaar or Detas: | | | | edent of the ecify Cuba | lispanic Origin? an, Mexican, Pu Specify: | (Specify Yas or Nerto Rican, atc.) | o- 14. Rac Bla Specify | ee - Amarican Indian, ck, Whita, afc. | |
| - CTZT: | permit. Pages 1 and 2 should be filled within 72 hours Department of Health and Mental Hygiene. Important: If ten 27 is marked other than "natural; any injury or other traumatic svent, tre Medical Expine. To Be Completed by | ompleted | 15. Decedant's Elemantary/Secondery (0-12) | ada completed) | (Give College (1-4or 5+) | | | edent's Usual Occupation a kind of work done during most of work DO NOT use retired) eautician | | | | usinass/Industry | |
| bug | | | 17. Fathar's Nama (First, Middla, Last) Samuel Pleasant | | | | | 01411 | 18. Mother's Nama (First, Middle, Maiden Surnama) Edna Golf | | | | |
| E 2 | | | 19a Informant's Name/Ralationship Anita Robinson/ | | | | | | and Number or | Rural Routa Num Upper Ma | | Stata, Zip Code) Maryland 207 | 74 |
| o - | | | 20a. Mathod of Disposition 1 Buriel 2 Crametion 3 [4 Donation 5 Othar (Special Content of the | | | Place of Dispos cematary, cremit ropolit | atory of | other pla | | 1-13-00 | | City or Town, Stata dria, Virgini | a |
| Ball | | 21. Signature of Funaral Sarvice Lice 23a. Part. Entar tha disease, or corshock, or heart failura. List only | & Ba | tha deat | n 4 | 308 | Sui | tland Ro | d. Suit | Land, MD | 20746 Approximata Interval Between | | |
| | nysician Medical xaminer | | Immediata Causa (Final disease or condition rasulting in daath) | a Caxdo | | maneny or as a consequ | | | | | | Onset and Death | |
| OX DS/ | ficate be executed by physician and as the burist-transit edical Examiner | edicai | Sequentially list conditions, if any, laading to immadiata causa. Entar Undarlying Cause (Disease or injury that initiated events rasulting in death) Last | c. duch | Dua to (c | mellity | م | | | | | t t t t t t t t t t t t t t t t t t t | |
| Par Pe duar | ed by the detached | by Physician/M | Part II. Other algorificant conditions Shama | contributing to death b | ut not ras | ulting in the und | derlying | causa gin | ren in Part I. | | tobacco une co | ntribute to the cause of de | |
| ecords | has been sign ge 2 should be | Completed b | hyportension | | | | | | | 24a. Wa | s an autopsy formed? | 24b. Wara autopsy tindir available prior to completion of cause of death? | |
| Tal H | certificate hu rector, page | | | | | | | 4 | | | Yas 200 | 1 Yas 2 No | |
| | centil | o Be | 25. Was casa rafarrad to medical axaminar? 1 ☐ Yas 2 ☑ No | Hospital: | | 500 | •□ | Ott | Mar: | Death (Check only | | (0 - 11) | |
| SION OF VI | | - | 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation | 28e. Data of Inju (Month, Da | iry | 28b. Tima of Injury | 3□ I | 28c. Inju | 4 IADIZEL | 9 Homa 5 ☐ Ras 28d. Describe | how injury occur | | |
| DIVIS | n after des al Director ad in by th | Certification: | 3 Suicida 6 Could not datarminad | | ury - At h | oma, farm, stre | et, facto | ory, office | | 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) | | | |
| e Hospit | n 24 hou se Fumen sletsky IIII | edical | | hysician: To the best miner: On the basis o and mannar st | faxamina | | | | | | | annar as stated. and due to tha cause(s) | |
| | E 0 E | ž | 29b. Signatura and titla of certifiar | | | | 2 | 9c. Licens | e number | | 29d. Data signe | d (Month, Day, Year) | |

State Registrar

Plegsont

30. Nama and address of person who completed cause of death (Itam 23a) (Type, Print)

14. Crean ford - Green 7715 Bell Cynthia Crawford—
31. Data filed (Month, Day, Year)

JAN 1 3 2000 32. Registrar's Signatura

027650

1-11-2000

Greenbelt, md.

present the speaker

JOAL : LAGE

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | | Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death JANUARY 11,2000 THERESA CAROLINE PACE 8:50am 4e Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death PRINCE GEORGES SOUTHERN MARYLAND HOSPITAL CLINTON If Under 1 Year If Under 24 Hra 8. Dete of Birth (Month, Day, Year) JULY 29, 1920 5. Sociel Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Deys 1 M 2 F Hours COLRAIN, NC 79 Yes 577-28-2343 Usuel Residenca of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits PRINCE GEORGES UPPER MARLBORO Yes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20772 8006 ROSARYVILLE RD UNITED STATES 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Meritel Stetus 1 Never Married 2 Merried 1 Yes 2 No Specify: BLACK Specify: 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) HOMEMAKER 10 PRIVATE 17. Father'e Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) BESSIE MAE WEAVER GEORGE OUTLAW 19a. Informant's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) GEORGE PACE/ SON 8006 ROSARYVILLE, UPPER MARLBORO, MD 20772 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, State 1 Burlel 2 Cremetion 3 Removel from Stete HARMONY MEMORIAL PARK 1-17-QO LANDOVER, MD 4 ☐ Donation 5 ☐ Other (Specify) of Funeral Service Licens 22. Name end Address A FACILIER S. POPE FUNERAL HOME 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feiture. List only one cause on each line. 5538 MARLBORO PIKE, FORESTVILLE, MD 20747 Approximate Interval Between Onset and Death Immediete Cause (Finet hone disease or condition resulting in death) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 20 1 Yes No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? 1 Yes 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospitel: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 □ ER/Outpatient 3 □ DOA 27. Meprier of Death

Physician /Medical Examiner

Examiner

Be Completed by Physician/Medical

Physician

/Medical

Examiner

Funeral

Director

Show

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Reme :

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Director

Funeral

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Be Completed

Maryland

the th

filed within 72 hours after

Pages 1 and 2 should be nent of Health and Mental

of Health a other

= 8 permit. Page Department of Important: If any Injury or

21215-0020

Baltimore, Maryland

4 1/3

The law requires that the death certificate be executed burial-transi and Box 68760. the for use as P.O. Division of Vital Records, After this certificate has page 2 or Attending Physician: funeral director,

Certification: To To the Hospital or Attendir within 24 hours after death, To the Funeral Director: Af filled in by Medical npletely

State Registrar 30. Neme and address of person who completed cause of death (Item 23a) (Type,

5 Pending investigation

6 Could not be determined

1 Natursi 2 ☐ Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier

31. Date filed (Morfin, Day, Year)

JAN 1 2 2000

32. Registrar's Signeture

28b. Time of

28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28a. Dete of Injury (Month, Dey Year)

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examinetian and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated.

29c. License number

1 Yes 2 No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

DHMH 16 Rev 6/95

9005 3 C MAN

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** January 6,2000 WALTER JACKSON PETTY 2:40 A.M. /Medical 4b. City, Town, or Location of Death 4s Facility Name (If not institution, give street and number) 4c. County of Death Examiner Clinton
If Under 24 Hrs.
Hours Min. SOUTHERN MARYLAND HOSPITAL Prince George's 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) 6 Sex Birthplace (State or Foreign Country) **Funeral** 1₩ M 2□ F 85 Months Days Director March 6,1914 Wash., D.C. 578-05-3153 the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f ahow the Medical Examiner must be notified at 1 Yas 2 □ No Director Washington, D.C. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 20001 USA 414 "W" Street, N.W. Apt. 22 23a death Funeral Herne ? 12. Was Decedent Ever in U,S. Armed Forces? 1 (A)Yes 2 □ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puerto Rican, atc.) 14 Race - American Indian 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiena. Important: if Item 27 is marked other than "natural; or Item any Injury or other traumatic avent, the Hedge Emminance Black, White, etc. 1 □ Never Married 2 □ Merried Baltimore, Maryland 21215-0020 1□ Yes 2 No Specify: Specify: Black g 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Cab Company 12th Dispatcher 17. Father's Neme (First, Middla, Last) 18. Mother's Nama (First, Middla, Maiden Surname) Be Belinda Gray Theodore Petty 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a, Informent's Name/Relationship (Type, Print) 414 "W" St., N.W. Apt. 22 Wash., D.C. 20001 Kathryn Curry/daughter 20a. Method of Disposition 20b. Place of Disposition (Nama of cemetery, crematory or other place) 20c. Location - City or Town, Stata 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Quantico National Cemetery Quantico, Virginia 22. Name and Address of Facility Frazier's Funeral Home, Inc. 21. Signature of Funeral Service Licenses 389 Rhode Island Ave., N.W. Wash., DC 20001 clications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, one cause on each line. 23a. Part 1. Enter the disease, or com-Approximate Interval Betw Onsel and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner (or as a consequence of): Examine aulure ician and burlal-transit The law requires that the death certificate be assocuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last alsolic physician at the burial Box 68760. Physician/Medical Obstruction USB Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed Dege 2 certificate has 1 Yes 2 No 1 Yes 2 No Division of Vital Physician: 25. Was case referred to medicat examiner? Be 26. Place of Deeth (Check only one) 1 Yes 2 No Hospitaf: Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To this funeral 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After or Attending 1 Natural 5 Pending investigation 1 Yes 2 No 24 hours after death.

Funeral Director: A 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28t. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of tnjury - At home, ferm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical completely (Check only within 2 To the 29b. Signature and title of certify 29c. License number 29d. Data signed (Month, Day, Year) arimi all D 05299 January 7, 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1328 Southern Avenue, S.E. #200 Wash., DC 20032 Rahimian

DHMH 16 Rev 6/95

State

Registrar

31. Date filed (Month, Day, Year)

JAN 1 0 2000

32. Registrar's Signature

and the second

State of Maryland / Department of Health and Mental Hygiene 00 2356

Certificate of Death

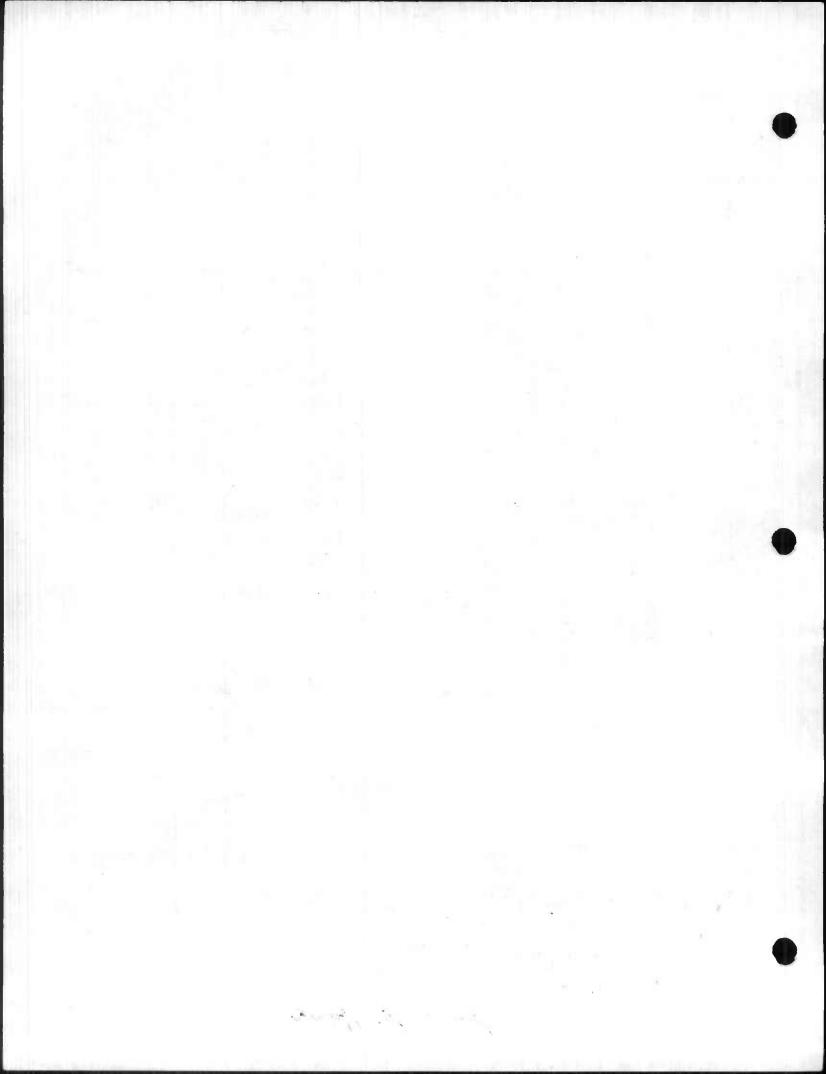
| | | | | Ce | rtificate d | of Death | | Reg. No. | | | | |
|-------------------------|-------|--|--|--------------------|------------------------------------|--|--|---|-----------------|---|---|--|
| €., | _ | Decedent's Name (First, Middle, La | st) | 101 | | | 2. Dete of De Month | | Yeer | 3. Time of Death | | |
| nysician Medical | | THOMAS WAYNE | PROCTOR | | | | JANUAF | | 2000 | 0820 AM | | |
| aminer | 46 | Facility Name (If not institution, giv | e street and number) | | | 4b. City, Town, | or Location of Deel | | | | | |
| | L | 7970 PENN RANDA | LL DRIVE | | | FOREST | | | NCE C | EEORGES | | |
| 1 | | Social Security Number 6. S | ex 7. Age (In yrs. XM 2□ F 4. | | Months De | | lin. 8. Dete of Bi (Month, Di October | rth ay, Year) | Coul | place (State or Foreign | | |
| | | 12-71-0377 | 23. | T TIS. | | | uctober | 13,1955 | washi | ngton, D.C. | _ | |
| | - | Suel Residence of Decedent Da. Stete 10b. County | 10c. Cit | y, Town or L | ocation | | | | 1 | 10d. Inside City Limits | | |
| ò | N | Maryland Prince G | eorge's II | oner M | arlboro | | | | | 1 O(Yes 2 □ No | | |
| Directo | 10 | De. Street and Number | 0.000 | ppcr | 10f. Zip Coo | 0 | | 10g. Citizen of | Whet Cou | ntry? | - | |
| | | .5315 Leeland Roa | d | | | 20774 | | U.S | U.S.A. | | | |
| Funeral | 11 | 1. Marital Status | 12. Was Decedent Ever in U Armed Forces? | ,S. 13. | Was Decedent | /as Decedent of Hispenic Origin? (Specify Yes or No- Yes, specify Cuban, Mexican, Puerto Rican, etc.) | | | | 14. Rece - American Indian, Black, White, etc. | | |
| | | 1 Never Merried 2 Married | 1 Tes 2 No | | 1 Yes 2 | | Jones Filodri, Olo., | Specify: | | | | |
| d by | | 3 ☐ Widowed 4 🖺 Divorced | Yeer or Detes: | | | TO Option, | | 16b. Kind of Business/Indus | | | | |
| Completed | | 15. Decedent's Ed (Specify only highest gra | ducation ide completed) | 16e. Dece (Give | dent's Usual Oc kind of work do | cupation ne during most of tired) | working | 16b. Kind of B | usinass/In | dustry | | |
| d E | | Elementary/Secondary (0-12) | College (1-4or 5+) | | | | pairman Private | | | | | |
| | | 12th 7. Fether's Name (First, Middle, Last) | | Auto | b body i | - | Name (First, Middle | . Maiden Sumar | | | | |
| o Be | | Thomas Eugene Pr | | | | | y Helen Butler | | | | | |
| F | - | 9a. Informent's Neme/Reletionship (| | 19b. Mail | ing Address (St | | mber or Rural Route Number, City or Town, State, Zip Code) | | | | | |
| | | Mary Helen Proct | | | | | | | | land 20774 | | |
| | 20 | De. Method of Disposition | | Place of Disp | osition (Name o | 1 | 01/08 | 20c. Location | - | | | |
| | | 1 X Buriel 2 Cremation 3 4 Donation 5 Other (Specific | Hemoval from State | | memoria] | | 2000 | Landove | r. Ma | arvland | | |
| | 2 | Signeture of Funeral Service Licer | | | | Idress of Facility | | | 1 / 114 | aryrana | - | |
| E. | | A IA | 0 1. | | | ERAL HOMI | | rular | nd 20785 | | | |
| | 2 | 23a. Part1. Enter the disease, or com shock, or heart feiture. List only | plications that caused the deal | | | | | | 1 7 1 41 | Approximate Interval Between | | |
| Examiner | re | isease or condition esuiting in death) | b | or es e conse | quenca of): | A COLUMN | | | | | | |
| edicai E | | Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Last Due to (or es e consequence of): Due to (or as e consequence of): | | | | | | | | | | |
| 2 | | | d | | | | | | i | | - | |
| Physician/ | - | | A D. Alexander of the A. A. A. A. | h | 1. 1. 1 | -1 1- D-41 | non Die | (Anh | an And broken d | a Aba anuna ad dantha | _ | |
| ys | . 1 | art II. Other significant conditions o | ontributing to death but not res | sulting in the i | underrying cause | given in Part I. | 23b. Did tobacco use contributs to the cause of | | | | | |
| by P | | | | | | | | 2/4/10 | 00110 | , see, , , , , , , , , , , , , , , , , , | | |
| Completed b | | | | | | | 24a. Wa | s en autopsy formed? | av cc | Vere autopsy findings veilable prior to ompletion of cause i death? | | |
| Эшо | | | | | | | 150 | Yes 2□No | | Yes 2 No | | |
| 0 | 2 | 5. Was case referred to medical | | | | 26. Place of | Death (Check only | | - | | | |
| To B | | axaminer? YÖğes 2 No | Hospitel: 1 Inpatient 2 | ER/Outpatie | nt 3 DOA | Other | ng Homa 5□ Res | | her (Speci | (y) AT SCEN | - | |
| | | 7. Menner of Death | 28a. Dete of Injury (MONTH, Dey Year) | | or(fam) 28c. | | 28d. Describe | how injury occu | rped | | ĺ | |
| atio | | 1 Neturel 5 Pending investigation | 113/60 | 8:15 | | 1 Yes 2 No | 2011 - 2121 | CARBON A | nonux | DE | | |
| Certification: | | Suicide 8 Could not be determined | On Diana of Johns At h | (v) | treet, fectory, off | | 28f. Location City or To | (Street and Num own, State) 1190 ORESTVILLE | Der or Rui | A RANDAL DRIVE | | |
| edical Certification: 7 | | 9a. Certifier (Check only XXMedical Exam | ysician: To the best of my kno niner: On the basis of examine | owledge, deat | th occurred at th | e time, dete and p | ece, and due to the | cause(s) end m | anner as | stated. to the cause(s) | | |
| | | one) | and manner stated. | | | | 2.000 | | | | | |
| - 2 | 25 | 9b. Signeture and title of cartifier | 11. | | 29c. Lic | ocmE | | JANUARY | | | | |
| 1. | | y MI | (MIII) | | | | | OTHIOPH(I | 1, 4 | | | |
| / | 30 | | completed cause of death (Iter | | | Delti | 24 | -land 211 | 201 | | | |
| | | JACK M. TITUS | | | street | , partim | ore, Mary | Tand 21 | ZUI | | - | |
| State egistrar | 3 | 1. Date filed (Month, Day, Year) JAN 1 0 2000 | 32. Registrar's Sign | eture | wh/ | , Darcini | ore, Plary | TORU ZI | LUI | | | |

DHMH 16 Rev 6/95

PER ! WAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month Physician MARVIN PAUGH 22145 LEROY 2000 01 /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HOJEFAL Momorrac GARRETT OAKLAND GUARROTT If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthdey) Birthplace (State or Foreign Country) **Funeral** Hours Days 12M 2□ F Months 220-26-9363 69 **Director** Dec. 5, 1930 Maryland Usual Residence of Decedent 10a. Slate 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Nes 2 No Director MD Garrett 28a-1 0akland must be notifi 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or flams 23s or 103 Oak Hall Drive 21550 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian. Black, White, etc. 1 ∑Yes 2 No If Yes, Give Year or Dates: 1948-85 1 ☐ Never Married 2 Narried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: þ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Par Elementery/Secondary (0-12) 8th College (1-4or 5+) permit. Pages I and 2 should be filed w Department of Health and Mantal Hygien Important: if hem 27 is marked other th any injury or other transment. Custodian State of Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) 8 Murray Edward Paugh Carrie Mae Haskell 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Irene Paugh/Wife 103 Oak Hall Drive, Oakland, Md. 21550 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrett Co. Mem. Gardens 1/17/00 Oakland, Maryland 21. Signalure of Funeral Service Licenses 22. Name and Address of Facility Stewart Funeral Home 32 S. Second St., Oakland, Md. 21550

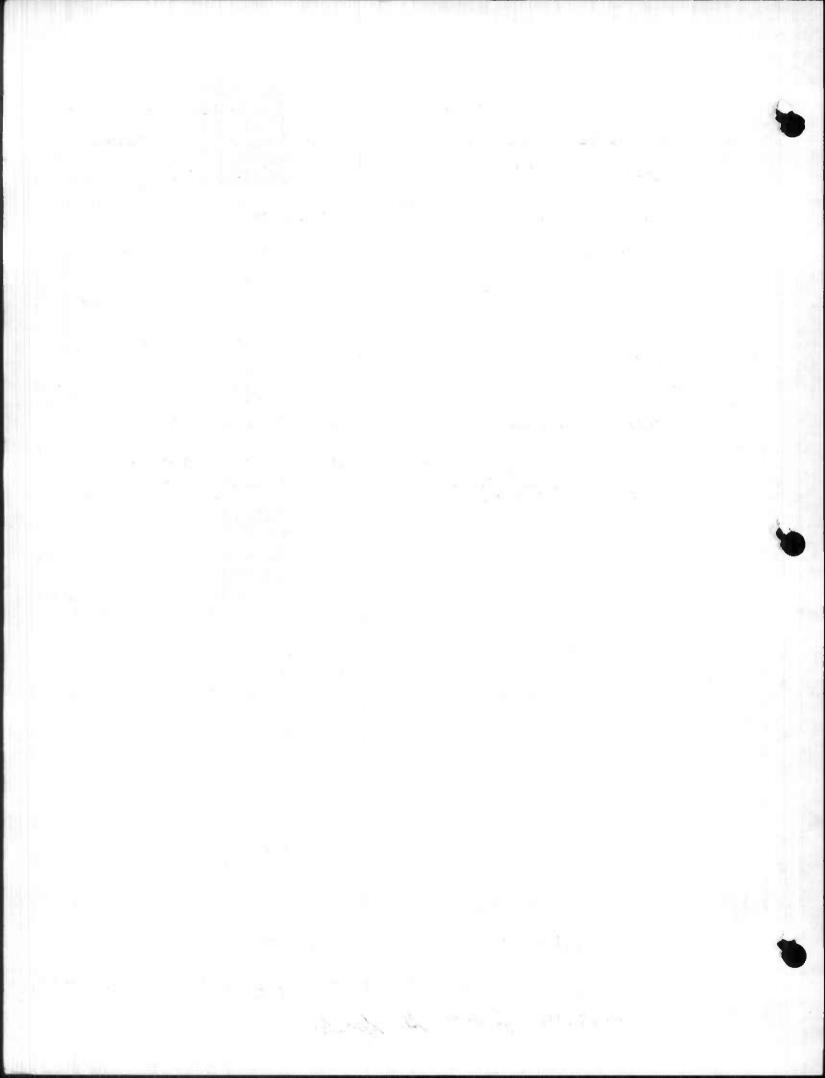
23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediete Cause (Final diseese or condition resulting in death) ANCREAFIC Examiner Due to (or as e consequence of). Examiner CIASMOIN FOS FINAC physician and the burial-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequence of): Box 68760 Physician/Medical Due to (or as a consequence of): Part It. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 23h. Did tohacco use contribute to the cause of death? 1 Yas 2 No 3 Probably 4 thknown Records, ģ 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed has 1 Yes 2 No 1 Yes 2 No Division of Vital Be 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No 1 Inpetient 2 ER/Outpetient 3 DOA this 27. Menner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 1 Natural 2 Accident or Attending 5 Pending investigation death. 1 Yes 2 No after death 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28t. Location (Street and Number or Rural Route Number, City or Town, Stele) 4 Homicide 24 hours after Funeral Dire letely filled in b Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical To the Fune completely f (Check only within 2 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of conflier 29c. License number D0051564 JAN 15, 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20+1UF 311 NORTH FOURTH ST DAKLAND MD MD ZAKALLEZ 31. Date filed (Month, Day, Year) Registrar's Signature State 2000 Registrar JAN 18



State of Maryland / Department of Health and Mental Hygiene

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| | Physic /Medi | | Ethel M | irfin P | reston | | | | | an 3, | | | 8: | 30 pm |
| 3 | Exami | | 4a. Facility Neme (If not institution, g Continuum Care | | 1111 | | | 4b. City, Town | | 1111-1111 | 4c. County | | 1.7 | |
| | | | | | 7. Aga (In yrs. la | et hirthdayl | if Under 1 Yaar | | Sville | | | Carro | | ta or Foreign |
| | Funeral Director | | 212-20-7704 Usuel Residence of Decedent | 1□ M 20XF | 84 | Yrs. | Months Deys | | Min. De | ete of Birth Month, Day, Y | 915 | Coun | ylan | |
| | yland | | 10e. Stete 10b. County | | 10c. City, | Town or Lo | | | | | | 1 | 0d. Inside | City Limits |
| | r 28a-f show | ctor | Maryland Carr | oll | | | | Westmi | nster | | | | 1 🗆 Y | as 20 No |
| | th with | al Director | 10e. Street end Number 30 Locust Lane | | | | 10f. Zip Code | 21. | 157 | 10g | 10g. Citizen of What Country? USA | | | |
| | Herra Herra Inst. Im | Funeral | 11. Meritai Status | 12. Wes Dece Armed For | dant Evar in U,S | . 13. | Wes Decedent of I f Yas, specify Cub | lispanic Orlgin an, Maxican, F | ? (Specify) | (as or No- | | - Amaric | | |
| Maryland 21215-0020 | 72 hours efte "natural", or it | by | 1 ☐ Never Merried 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced | If Yes, Giv Year or De | 0 | | 1□Yas 2⊠No | | | | Specify. | | hite | |
| 5 | neth Police | lete | 15. Decedant's (Specify only highest g | | | 16e. Deced | dent's Usual Occup kind of work dona DO NOT use retire | pation during most o | f working | 16 | b. Kind of Bu | siness/Inc | lustry | |
| 12 | filed withir Hygiene. other than ent, the Man | Be Completed | Elamantary/Secondery (0-12) | Coilege (1 | -4or 5+) | me. | Sewing | 0) | | | Sewi | ing F | 'acto | ry |
| P | 12 should be filed v h and Mental Hygie 7 is marked other t irsumatic event, to | Ö | 17. Father's Neme (First, Middle, Las | st) | | | | 18. Mother's | Name (Firs | t, Middle, Ma | iden Surnam | e) | | |
| /lar | Aenta rked tic ev | To B | Fred Mirfin | | | | | Mar | y Kilo | coyne | | | | |
| lan | d 2 should be filed in and Mental Hyg 7 is marked othe traumatic event, | | 19e. Informent's Neme/Reletionship | | | | ng Address (Street | | | | | Stete, Zip | Code) | |
| | 1 and 2 Health em 27 I | | Frederick Prest | on, son | | | Willow S | t., Hai | - | | | | | |
| 0 | Pages 1 and ment of Healt ant: If Item 27 ury or other | | 20e. Method of Disposition 1X Buriei 2 ☐ Cremetion 3 | ☐Removel trom : | Stete | m <i>etery, cre</i> r | sition (Neme of matory or other ple | | Da | | c. Location - | | | |
| Baltimore, | t. Pa rtmen rtant: | | 4 Donetion 5 Other (Spec | | The same of the sa | _~ | ead Cemet | | 1/7 | | Hampst | | MD | |
| Bal | permit. Pages 1 and Department of Health Important: if item 27 any injury or other to once. | | 21. Signeture of Funerei Sarvice Lic | ensee 16V | M00723 | 22 | 2. Neme end Addre | | | ne Fur | | | 074 | |
| | | Н | 23a. Pert1. Enter tha disaasa, or co | vu | m | Do not not | 934 Sou | | · · · · · · · · · · · · · · · · · · · | - | | עט צד | U/4 Approxir | |
| , | Physician /Medicai Examiner |). | shock, or haert feilure. List onl Immediate Cause (Finei disaasa or condition resulting in deeth) | e | | RES P | IRATORY Juence of): | · F | AIZU | re | | | | nd Deeth |
| | the death certificeta be executed by the attending physician and sched for use as the burial-transit | Examiner | Sequentially list conditions, | b | Due to (or | HLON es e consec | uence of): | STRUCTI | uz L | NG E | 15 CASI | = | 109 | CARS |
| 68760, | iceta be ex physician s the buria | edical E | Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events | c | Dua to (on | | | | | | | | | |
| 68 | ertificet ling phy e as the | Medi | resulting In death) Last | | Due to (or t | as a conseq | uance ot): | | | | | | | |
| Box | attendin for use | | | d | | | | | | | | i | | |
| | that the death co | Physician/ | Pert II. Other significant conditions | contributing to de | ath but not rasult | ting in tha u | ndarlying cause gi | ven in Pert I. | | 23b. Did tobe | cco use con | tribute to | the cau | se of death? |
| P.0 | d by 1 | | | | | | | | | 1 🗆 Yee | 2□ No | 3 Prot | oably 4 | Unknown |
| of Vital Records, | 8 5.8 | d by | | | | <u> </u> | | | | No. Wee ear | | 24h Wa | ere euton | sy tindings |
| Ö | _ 00 | Completed | | | | | | | | 24a. Wes en a performe | d? | ave co | eilable pri mpletion | or to |
| Rec | has has | dw | | | | | | | | | -00. | | death? | |
| a | delan: The | | 25. Wes case reterred to medical | | | | | 00 Diversi | 15-11-101 | 1 Vas | 2 15 No | 11 | Yes 2 | 2∐ No |
| 5 | | To Be | examinar? | Hospitei: | npatient 2 E | R/Outpatier | nt 3 DOA Oti | | | <i>eck only one)</i> 5 □ Residend | ne 8 🗆 Othe | ar /Snacif | (r) | |
| o | a Phys er this eral di | | 27. Mannar of Deeth | | | 28b. Time of | | | - | Describe how | | | '/ | |
| <u>io</u> | Attending I r death. ector: After by the funer | atio | 1 Neturel 5 Pending 2 Accident investigati | on | ii, Dey Tear) | Injury | | Yes 2 □ No | | | | | | |
| Division | Direction | Certification: | 3 Sulcide 6 Could not determine | 286. Piece | of Injury - At honing, etc. (Specify) | ne, farm, str | eet, tactory, office | | 28f. L | ocation (Stre City or Town, | et end Numbe Stete) | er or Rure | I Route A | lumber, |
| | Ne Hospital n 24 hours Ne Funeral bletely filled | edical | 29a. Cartifier (Check only one) 1 ☐ Certifying F | Physician: To the aminer: On the ba | sis of examinetic | on end/or In | occurred et the ti vestigation, in my | opinion, deeth | occurred et | the time, dete | end piece, e | and due to | the caus | |
| 1 | vithin 2 To the | Σ | 29b. Signeture end title of Pertillier | 0 - 4 | ı.D. | | 29c. Licens | sa number | 00 | 290 | l. Deta signed | (Month, | Dey, Yea | r) |
| 3 | | |) S. Ke | \sim | 1, 1, 1 | | 1 | -126 | 07 | | JANU. | my 6 | - 20 | 000 |
| | | | 30. Name and address of person who | completed caus | e of deeth (item: | 23e) (Type, - 745 | - 0 | VACE | BRANC | cut lo | (61G | BUR | ME | rd 21000 |
| | Sta | | 31. Dete tiled (Month, Day, Year) | | egistrer's Signetu | ire | - | | | | | | | |
| | Registi | | JAN 072 | טטט 🏻 | Zeneva | Ø. | pour | 2 | | | | | | |
| DH | IMH 16 Rev 6/9 | 5 | | - | | | . / | | | | | | | |



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Des Month Lillian Rose Robinson 2/30 JANUALY 14, 2000 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO If Under 1 Year B. Date of Birth (Month, Day, Year) Jan 30, 19 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 M 2 F Months Deys Hours Maryland 218-20-2642 Usual Residence of Decedent 10a. Stete 10b, County 10c. City. Town or Location 10d. Inside City Limits Maryland Dorchester Toddville 1 ☐ Yes X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2748 Toddville Road 21672 US 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Merried 1 Yes 2 No Specify: specify: White 3X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Crab Picker Seafood 17. Father's Name (First Middle Last) 18 Mother's Name /First Middle Maiden Sumamel Romie W. Robinson Hattie Robbins 19a. Informant's Neme/Relellonship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Ramona R. Mills Daughter 2528 Toddville Road Toddville, Maryland 21672 20e. Method of Disposition 20b. Plece of Disposition (Name of cametery, cremetory or other place) 20c. Location - City or Town, State XXBurial 2 Cremetion 3 Removel from State MD Veterans Cemetery 1/17/2000 Hurlock, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Murrerel Service Licensee 22 Name and Address of Facility Thomas Funeral Home, P.A. 700 Locust Street Cambridge, Maryland 21613 23e. Pertiventer the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Death = Months Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, teeding to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) thet initiated events resulting in death) Last Due to (or es a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown

Physician/Medical Examiner ician and burial-transit The law requires that the death certificate be executed physician the burial Box 68760, 93 USB signed by the a P.O. Division of Vital Records. þ Completed Be Certification: To or Attending death. 24 hours after deal Funeral Director:

filled in by

completely To the P within 2

Physician

/Medical

Examiner

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21215-0020

Maryland

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Pages 1 and 2 should

tant: If Item 27

Physician

/Medical Examiner

| | | 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? | | | | |
|--|--|---|--|--|--|--|
| | | 1 Yes 2 No 1 Yes 2 No | | | | |
| 25. Was case referred to medical | 26. Pla | ice of Death (Check only one) | | | | |
| exeminer? | Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 I | Nursing Home 5 Residence 6 Other (Specify) | | | | |
| 27. Menner of Death Netural 5 Pending 2 Accident Investigation | | 28d. Describe how injury occurred ☐ No | | | | |
| 3 Sulcide 6 Could not be determined | 28e. Pteca of Injury - Al home, ferm, street, fectory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) Certifying Physics Certifying Physics Certifying Physics Medical Example | ing Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as si il Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to end menner steted. | | | | | |

29b. Signature and title of certifier ramo

person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

State

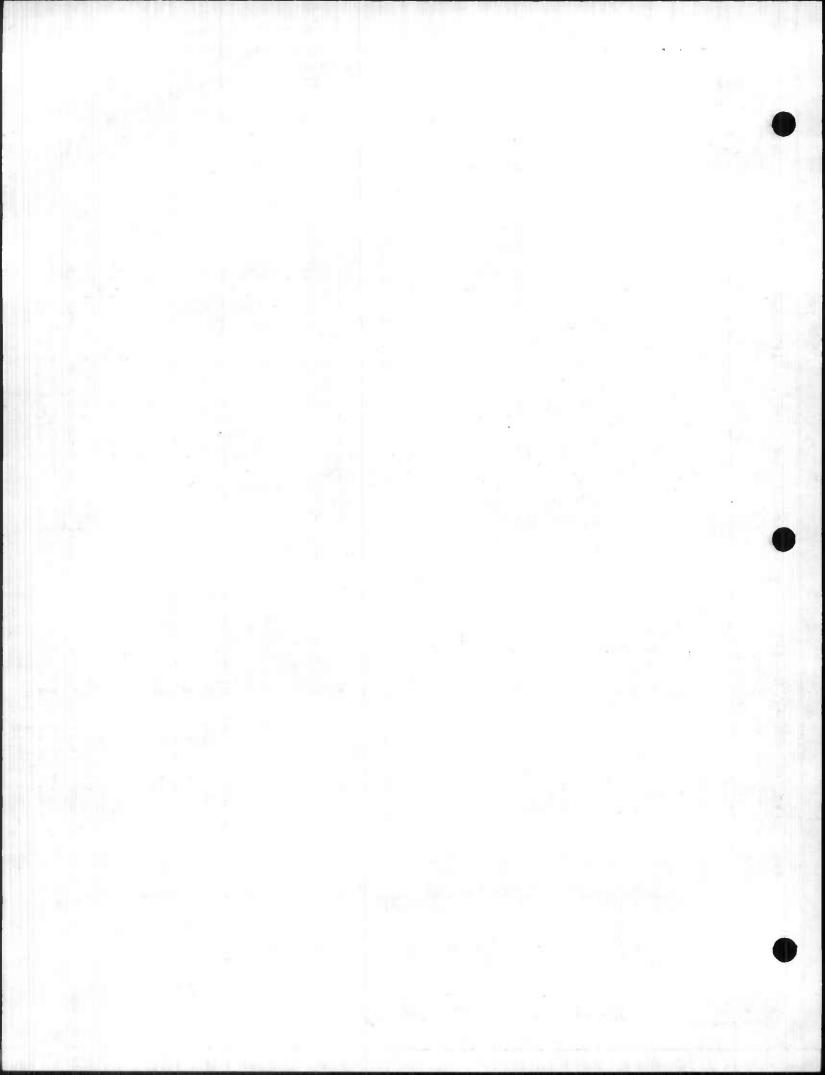
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19320K 31. Date filed (Month, Day, Year) JAN 18 2000

MY MRASSO 145 32. Régistrer's Signature

CARROLLST SAUSBURY MO

Registrar



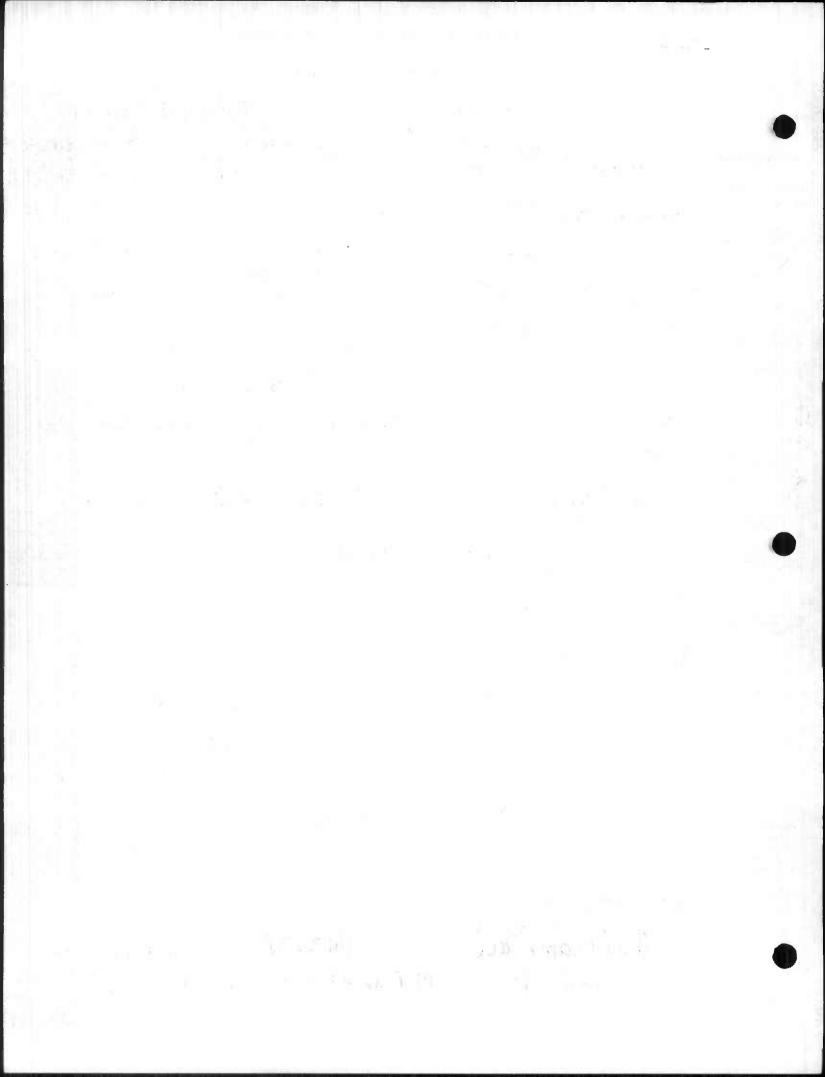
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Name (First, Middla, Last) 2. Date of Death 3. Tima of Death **Physician** Month 15 Ruth The1ma Runge 2000 January 15 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner tos? THE GENERUL URCHESTER AMBRIDGE PRICHESTER If Under 24 Hrs. 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) 9. Birthplaca (State or Foreign Country) **Funeral** 1□M 2∰F Days Hours 218-18-8645 75 Director Maryland Usual Rasidance of Decedant 10a State 10b. Counts 10c. City, Town or Location 10d. Inside City Limits YAS 2 No Delaware Kent Dover Director 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? items 23s or traumetic event, the Medical Examiner must be 21 Par Haven Drive Apt. D-23 19904 US Funeral 12. Was Decedent Evar in U,S. Armed Forces? 1 □ Yas 私 No If Yas, Giva Yaar or Datas: Was Decedent of Hispanic Origin? (Specify Yes or No-it Yas, apecify Cuban, Maxican, Puarto Rican, atc.) 14. Raca - American Indian, Black, White, atc. 1 Navar Married 24 Married 6 1 ☐ Yas 2 No Specify: White à Specify: 3 ☐ Widowed 4 ☐ Divorced 'natural', 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Induatry Elemantary/Secondary (0-12) College (1-4or 5+) Practical Nurse Nursing 17. Fathar's Nama (First, Middla, Last) 16. Mothar'a Name (First, Middla, Maiden Surnama) Pages 1 and 2 should be I next of Health and Mental I unt if them 27 is marked of Elmer Emge Lillian Kelly 19a. Intormant'a Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zio Code) 21 Par Haven Drive Apr D-23 Dover, Delaware 19904 Department of Health important: If Item 27 Kenneth Runge Husband 20b. Place of Disposition (Nama of cemetary, cramatory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 K Cramation 3 ☐ Ramoval from State b 4 ☐ Donation 5 ☐ Othar (Specify) Salisbury Crematory 1/17/2000 Salisbury, Maryland 21. Signature of Funaral Service Licensee 22. Nama and Addrass of Facility Thomas Funeral Home, P.A. 700 Locust Street Cambridge, Maryland 21613 23a Party Entar the disaasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, should or heart tailure. List only one cause on each line. Approximate Intarvai Between Onset and Death Physician /Medical immediate Causa (Final ancreatith 3 weeks disease or condition rasulting in deeth) Examiner g physician and as the buriel-transit Sequantielly liat conditions, if eny, laading to immadiata cause. Entar Undarlying Cause (Disaasa or injury that initiated evants rasuiting in daath) Last Dua to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical Dua to (or as a consequence of): signed by the attending d be detached for use as Part Ii. Other significant conditions contributing to death but not resulting in the undarlying causa givan in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2/200 3 Probably 4 Unknown þ 24a. Was an autopsy performed? 24b. Wara eutopsy tindings available prior to completion of cause of death? Completed certificate 1 ☐ Yas 2 No 25. Was casa retarred to medical Be 26. Place of Death (Check only ona) axaminar? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yas 2 No 1 inpatiant 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28b. Tima of 28d. Dascribe how injury occurred 28c. Injury at Work? Certification: After 5 Pending invastigation 1 Netural 2 Accident death. 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fi 3 Sulcide 8 Could not be datamined 26t. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At home, farm, straet, tactory, office building, atc. (Specify) 4 Homicida 1 Certifying Physician: To the best of my knowledga, daath occurred at tha time, dete and place, and dua to tha causa(s) and mannar as stated.
2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, daath occurred at the time, data and place, end due to the cause(s) and mannar stated. 29a. Certifier Medical 29b. Signature and titie of certifian 29c. License number 29d. Date signed (Month, Day, Year) January 15, 2000 30. Nama and addrass of person who complained causa of death (Item 23a) (Type Print) Campridge, MD 21613 2011

DHMH 16 Rev 6/95

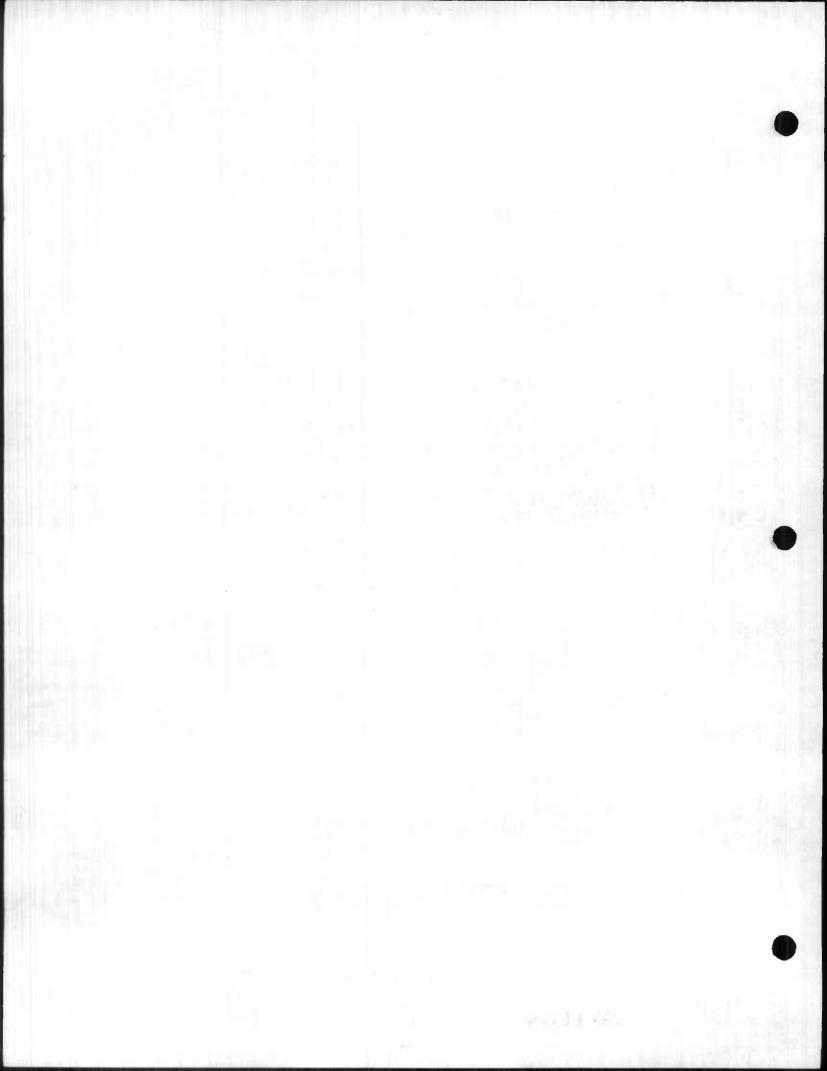
Registrar

31. Data tiled (Month, Day, Year)

32. Ragistrar's Signature



| | | | | | | Ce | rtificate | e of | Death | 7 | F | leg. No. | J | 2361 |
|--|----------------|---|--------------------------|-------------------------------------|-------------------------------------|--------------------------------|-------------------------------------|-----------|------------------------------|------------------------|--|----------------------------------|-----------------|---|
| | | 1. Decedent's Name (Fire | st, Middle, L | nst) | | 100 | | | | | 2. Date of Dea | | Mana | 3. Time of Death |
| Physi | | THOMAS W | OODROW | REICH | ARD | | | | | | Janua | rv 9.2 | 2000 | 1028 |
| /Med Exam | | 4a Facility Name (If not i | institution, gi | ve street and nu | mber) | | | | 4b. City, To | own, or L | ocation of Death | 4c. Count | | 1020 |
| LAGII | iiiiei | ф | he Me | morial | Hospi | tal | | | F | East | on | | Talk | oot. |
| Francis | , | 5. Social Security Number | | Sex | 7. Age (In yrs. | |) If Under | 1 Year | | 24 Hrs. | 8 Date of Birth | 1 | | |
| Funera Directo | | 210-05-4995 Usual Residence of Dece | | XX M 2□F | 82 | Yrs. | Months | Days | Hours | Min. | DEC. 28 | (Year) | | place (State or Foreign ntry) NSYLVANIA |
| Pu Res | | | County | | 10c. Cit | y, Town or L | ocation | | | | | | 1 | IOd. Inside City Limits |
| Se-f aho | Director | MD | TALB | OT | | | | STO | N | | | | | NXYes 2□No |
| .0020 hours after death with the Manyland ural, or flams 23a or 28a-f ahow | al Dire | 10e. Street and Number | GGINS | STREET | | | 10f. Zip | | 1601 | | | IOg. Citizen of US | What Cour SA | ntry? |
| Nor dea | Funeral | 11. Marital Status | AK. | 12. Was Dec Armed Fo | edent Ever in U | ,S. 13. | Waa Deced | lent of | Hispanic Or | rigin? (Sp | ecify Yea or No- | | ca - Amaric | ean Indian, |
| 020 urs afte | by | 1 Never Married 2 | | 1 XYes If Yes, Gi Year or D | 2 No WW | II | 1□ Yes 2 | | | | | Specif | | ITE |
| 5-0 72 ho | be | | Decedent's E | | | | dent's Usua | | | -A -of | | 16b. Kind of B | usiness/In | dustry |
| 21215-0020 d within 72 hours at plene. It than "natural", or the thing of the plene | Completed | Elementary/Secondary | | College (| | lite. | kind of wor DO NOT us 'SICIS' | e retire | aunng mo: ed) | ST OF WORK | ang | II S | COVE | RNMENT |
| | | 17. Father's Name (First, | Middle I as | 1) | | 1111 | 51015 | 1 | 18 Moth | er's Nam | e (First, Middle, | | | KMPIENI |
| Maryland d 2 should be file th and Mental Hy 7 le marked oth traumatic event | o Be | THOMAS CLA | | | | | | | | | ELL McGA | | | |
| aryla should nd Mer marks umarks | - | 19a. Informant's Name/F | Relationship | (Type, Print) | | 19b. Mail | ing Address | (Stree | t and Numb | er or Rui | ral Route Numbe | r, City or Town | , State, Zip | Code) |
| M 2 Dud 2 Dith a lith a 27 le | | KAREN REIC | | | HCHTER | 4543 | ROOM | F C | DEEK 1 | CAD | , OXFORD | MD 21 | 1654 | |
| The House | | 20a. Method of Disposition | | ANGIJUA | 20b. P | Place of Disp | osition (Nam | ne of | | TUAD | | 20c. Location | | own, State |
| Baltimore, semit. Peges 1 a Department of Heemportant: If them not Injury or othe | | 1 Burial 2 Cre 4 Donation 5 D | | | | ESAPEA | | | | CTR | 1-10-00 | CHEST | TER, | MD |
| Baltin pemit. F Departm Importar eny Injur | | 21. Signature of Funeral | | ** | | 2 | 2. Name an | d Addr | ess of Facil | ity | | | | |
| W FOR | | IN F | 1/210- | MAN | 11.155 | | | | | | | | | HOME, P.A. |
| | | 23a Part 1. Enter the dis | ease or con | polications that | aused the deat | | | | | | . EASTO | | 21601 | Approximate |
| Discontinuo | | 23a. Part1. Enter the dis ahock, or heart failu | re. List only | one cause on | | | | | | | | 1 | 1 | Interval Between Onaet and Death |
| Physician /Medica | | Immediate Cause (Final | | | 12.1 | | 1. | 1 | - / | | lord | 1 | | |
| Examine | | disease or condition resulting in death) | | a | athe | nos | Leve | ru | 0 | | | | | EVERAL YRS |
| | a | | | | Due to (o | or as a conse | quence of): | 7 | - | ,1 | usea c | 6.1 | Les S | EVERAL YRS |
| D D D | Examiner | | - | b | Dua to to | r as a conse | 7 00 | v | ory | W | ceed | Acce | 0- | 7 |
| certificate be executed ring physician and use as the burlat-transit | | Sequentially list condition if any, leading to immedicause. Enter Underlying Cause (Disease or injury | ate | | C > | as a conse | quence ory. | | | | | | | |
| 68760, ficate be ex physician as the burla | edical | that initiated events | - 5 | c | Due to (o | rae a conse | quence øf): | | / | | | ~4 | - | |
| X 687 | Med | resulting in death) Last | | | Cores | leno | 1/100 | _ 7 | Ls | 11 | 7-1 | luke | S | EVERAL YRS |
| Box eath cent attendin | AL V | | | d | 000 | 90 | 002 | 7 | | 10 | - | 0017 | 1 | |
| O. Bo a death the atter hed for u | Physician/ | Part II. Other algnificant | conditions | contributing to d | eath but not res | ulting in the s | underlying c | ause gi | iven in Part | t. | 23b. Dtd to | obacco usa co | ontribute to | o the cause of death |
| O. C. Litha | h | 6 |) - | 0 0 | Ca. | -01 | | | | | 101 | a 2 No | 3 □ Pro | bably 4 Unknow |
| S, P es that igned b | by F | | Nos | une | - W | er | | | | | | /\ | | |
| Cords requires been sign | 8 | | | | | | | | | | 24a. Was a perfor | | 24b. W | ere autopsy tindinga ailable prior to |
| () _ 0 0 | Completed | | | | | | | | - | | pendi | (IIIOU) | CO | mpletion of cause death? |
| I Recard The law | E | | | | | | | | | | 1 D Y | es 2 No | 1[| Yea 2□No |
| | | 25. Was case reterred to | medicat | | | | | | 26 Plac | e of Deal | th (Check only or | | | |
| | ToB | examiner? 1 ☐ Yes 2 ☑ No | | Hospital: | Inpatient 2 | ER/Outpatie | nt 3 DO | A Ot | her | 11/1/20 | ome 5 Resid | | her /Snecil | (v) |
| | | 27. Manner of Death | | | of Injury th, Day Year) | 28b. Time o | | Bc. Inju | | | 28d. Describe h | | | ,, |
| Vision Attending in death. | atio | 1 Natural 5 ☐ 2 ☐ Accident | Pending investigation | | in, Day Year) | Injury | M | | Yes 2 | No | | | | |
| Division or Attending after death. Director: After | He | | Could not be | 289. Place | of Injury - At he | ome, farm, at | treet, factory | , office | | | | | ber or Run | al Route Number, |
| O Page | Certification: | 4 🗆 Homicide | | buildi | ng, etc. (Specif) | γ) | | | | | City or Tow | n, Siere) | | |
| Divi: To the Hospital or All within 24 hours after of To the Funeral Direct completely filled in by | edical (| 29a. Certifier (Check only 201 | Certifying Pl | byeiclan: To the miner: Og the b | best of my kno- esis of examinat | wledge, deat tion and/or in | th occurred o | ot the ti | ime, date er opinion, der | nd place, ath occur | and due to the c red at the time, d | ause(s) and m late and place, | enner as a | itated. o the cause(s) |
| To the Within 2 To the comple | ₩ | 29b. Signature and filling | Position / | | 71 | / | 29c | . Licen | se number | | 1 2 | 29d. Date signe | ed (Month. | Day, Year) |
| or view | | // | 1 6 | VIIA | 1 N | - | 1 | 11. | 109 | 7 | | 1.1 | 0-6 | 2 |
| | | 11/ | Le | nu | 1 | - | 1 | 110 | 0/ |) | | 1-10 | | |
| | | 30. Name and worders of | | | e of death (item 40 S. W. | | | т. | EAST | N. N | 4D 21601 | | | |
| | | TERRY DET | | | | | TON D. | 1 . , | HWD I (|) II 6 II | m 21001 | | | |
| | tate | 31. Date filed (Month, Da | | | legistrar's Signa | / | 4 | - | | | | | | |
| Regis | tiai | JAI | VIO | 2000 | 1 | P | · py | on | Kal | | | | | |



BONNI S. ROSATTI

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

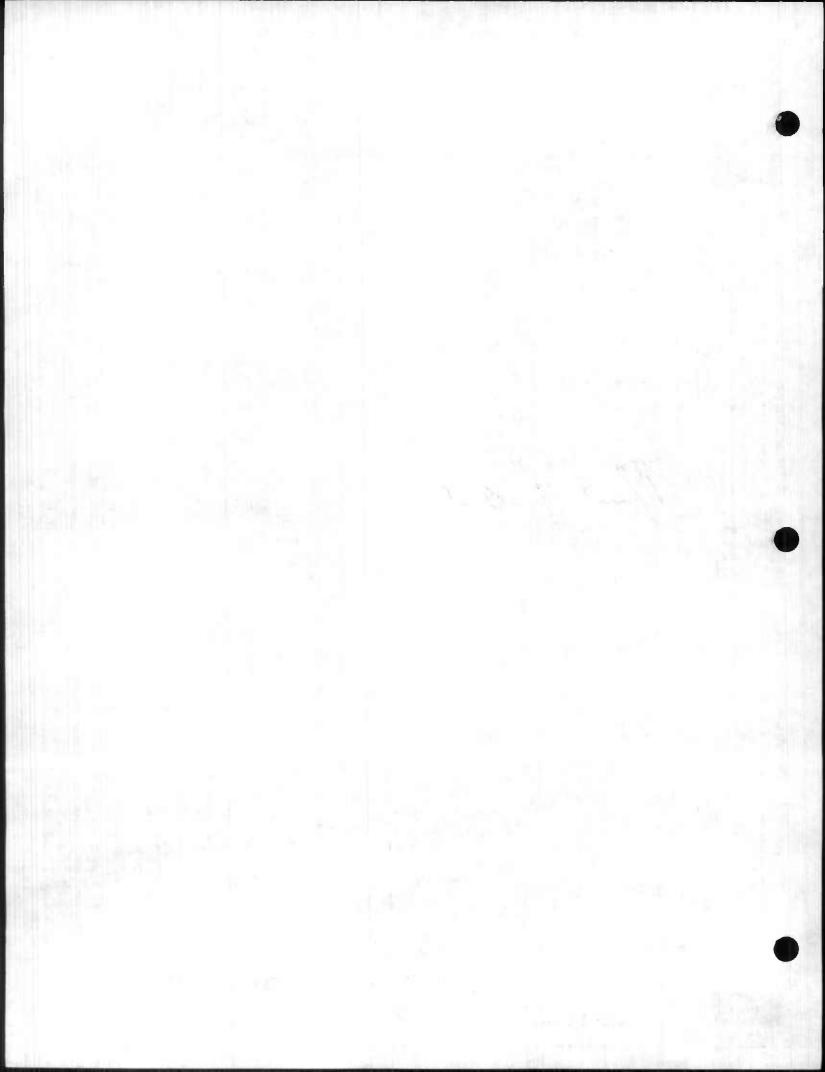
00 02362

| Physician | | me (First, Middle, La | 131/ | | | | | | | ate of Dec | eth Day | Year | 3. Time of Death |
|--|---|---|--|---|---|--|------------------------------|--|-------------------------------|--|--|---|---|
| /Medical | BONNI | | SANDRA | | ROSA | TTI | | | | AN. | 8, 2000 | | 0050 AM |
| Examiner | | (If not institution, given SYS NECK 1 | ve street and number ROAD | r) | | Name of | | City, Town | n, or Location | n of Death | | of Death | |
| Funeral Director | 5. Social Security 169-60-3 | NO 1970 - 14 P. L | | ge (In yrs. last | birthday) | If Under 1 Y Months Di | ear ays | If Under 24 Hours | Min. 8. D | ate of Birth Month, Day G.19, | 1964 | 9. Births | place (State or Foreign ntry) SYLVANIA |
| | Usual Residence | of Decedent | | 10c. City, To | own or Loca | tion | | | | | | | 10d. Inside City Limits |
| must be notified at neral Director | MD | TALBO' | T | 100.019,71 | | EASTON | | | | | | | 1 □ Yes 2 No |
| or 28a-fa be notified Directo | 10a, Streef and No | | T | | | 10f. Zip Co | | | | | 10g. Citizen of | What Cou | nfrv? |
| D P | 6010 8 | SHIPYARD : | LANE | | | | 160 | 1 | | | Į | JSA | |
| or Hear | | rried 2 Married | 12. Was Deceden Armed Forces 1 Yes 2 4 If Yes, Give Year or Dates | 2 NO | | s Decedent es, specify (| | panic Origin , Mexican, F Specify: | n? (Specify) Puerto Rican | Yes or No- n, etc.) | 14. Rac Bla Specif | ck, White, | can Indian, etc. ITE |
| ypiene. 4. the Medical Ex- | (Spe | 15. Decedent's E | | 10 | 6a. Deceder | nt's Usual Od nd of work do NOT use re | ccupati one du | ion ring most o | of working | | 16b. Kind of B | usiness/In | dustry |
| the Man | Elementary/Sec | condery (0-12) | College (1-4or | 5+) | HOMEMA | | etirea) | | | 200 | OWN H | OME | |
| | 17. Father's Neme | (First, Middle, Last | " | | | | 1 | 8. Mother's | s Neme (Firs | st, Middle, | Maiden Sumar | | |
| kad office variety | WILLIAM | F. DITZL | ER | | | | | SAND | RA PR | YOR | | | |
| a marin | 19a. Informant's i | Name/Relationship | (Type, Print) | 1 | 9b. Meiling | Address (St | reet an | nd Number | or Rural Rou | ıte Numbe | r, City or Town | State, Zip | Code) |
| 27 kg | JOHN A. | ROSATTI | /HUSBAND | | 6010 | SHIPYA | RD | LANE, | EAST | ON, M | D 21601 | | |
| ant of He ht: If Herr y or oth | | | Removal from State | ceme | tery, crema | ion (Name o tory or other IETERY | r place) |) | 1-1: | 2-00 | 20c. Location OXFORI | | own, State |
| itending physician and for use as the bunkil-fransit | Sequentially list of any, leading to cause. Enter Unc Cause (Disease of that initiated even resulting in death) | conditions, immediate | b | Due to (or as | | | | | | | | 0 0 | |
| ding Me | resulting in death) | or ińjurý its) Lest | d | Due to (or as | a conseque | | | | | | | | |
| | | Lest | d | | | nca of): | e given | n in Part I. | | | | | o the cause of death? |
| | | Lest | d | | | nca of): | e given | n in Part I. | | | obacco uaa cc Yaa 2⊠ No | | o the causa of death? bably 4 □ Unknow |
| igned by the a be deteched by Physic | | Lest | d | | | nca of): | e given | n in Part I. | | 1 🗆 ` | | 3 ☐ Pro | |
| has been signed by the age 2 should be deteched impleted by Physic | | Lest | d | | | nca of): | e given | n in Part I. | | 1 \(\) \(\ | Yaa 2 No | 3 Pro | dere autopsy findings vailable prior to ompletion of cause |
| ate has been signed by the a page 2 should be deteched Completed by Physic | Pert It. Other algn | ificant conditions | | | | nca of): | | | | 1 24e. Was perfo | an autopsy med? | 3 Pro | description of cause death? |
| ate has been signed by the a page 2 should be deteched Completed by Physic | 25. Was case referenced a saminer? | ificant conditions of | dcontributing to death | but not resulting | | nca of): erlying caus | Other | 26. Piece o : 4 ☐ Nursi | | 1 24e. Was perfo | an autopsy med? Yes 2□ No | 3 Pro | fere autopsy findings railable prior to mpletion of cause death? |
| death. stor: After this certificate has been signed by the a y the funeral director, page 2 should be deteched if cation: To Be Completed by Physic | Pert It. Other algn 25. Was case referenced examiner? | erred to medical No ath 5 Pending investigation of the could not be determined. | Hospital: 1 Inpa | but not resulting | Outpatient D. Time of Injury Outpatient, streen | nca of): erlying caus 3 DOA 28c. | Other: Injury a Work? 1 □ Ye | 26. Piece o : 4 ☐ Nursi | of Deeth (Chi | 24e. Was perio | an autopsy med? (es 2 No | 24b. Walland of the second of | dere autopsy findings railable prior to impletion of cause death? AYes 2 No |
| After this certificate has been signed by the a funderal director, page 2 should be deteched ilon: To Be Completed by Physic | 25. Was case referexaminer? 1 XIX es 2 C 27. Manner of Der 1 Natural 2 Accident 3 Suicide | erred to medical No ath 5 Pending investigation 6 Could not be determined | Hospital: 1 Inpa | but not resulting tient 2 ER/ jury ay Year) 2800 injury - At home, old. (Specify) t of my knowled | Outpatient Time of Injury Outpatient Time of Injury Outpatient Germ, stree | anca of): arriying caus 3 DOA 28c. M ccurred at the | Other: Injury a Work? 1 □ Ye | 26. Piece o 4 □ Nursi at as 2 ☑ No | of Deeth (Ching Home 28d. L | 24e. Was perfo | raa 200 No an autopsyrmed? res 2□ No res 2□ | 3 Pro 24b. Way occ of 1) her (Special rred driv ACCI ber or Rurura | dere autopsy findings railable prior to impletion of cause death? AT SCENTIFICATION AT SCENTIFICATION AND AT SCENTIFICATION AND AT SCENTIFICATION AND AND AND AND AND AND AND AND AND AN |

State Registrar Strohen S, Radentz 1111
31. Defe filed (Month, Day, Year) 32. Registrar's Signature

JAN 1 0 2000

111 Penn Street, Baltimore, Maryland 21201



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Physician 13, Norma L. Reynolds Jan. 2000 4:20 A.M. /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 12619 Kavanaugh Lane Prince Georges If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□ M 2⊠F 101 269-05-2476A Yrs. Director July 27, 1898 Ohio **Usual Residence of Decedent** 10b. County 10c. City, Town or Location 10d, Inside City Limits ahow 1□Yes 2□No Directo Md. Prince Georges Bowie 288-1 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? herns 23a or 3419 Memphis Lane 20715 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 20 No if Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, 11. Marital Status Bleck, White, etc. 72 hours after 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 "natural", or 1 ☐ Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working tife. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed w. Department of Health and Merial Hyglen freportant: if them 27 is marked other the any Injury or other traumetic event, the 2006. Millener Clothing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Henry Reynolds Wormel Ada 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3419 Memphis Lane, Bowie, Md. 20715 Joy Brillante Data 20c. Location - City or Town, Slela 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory Alexandria, VA. 21. Signature of Funeral Service Licensee. Blalf 22. Name and Address of Facility Beall Funeral Home Shannon W. Beall M00798 6512 N.W. Crain Hwy., Bowie, Md. 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feiture. List only one cause on each line. Approximete Intervel Between Onset and Death **Physician** ESPIRATORY TRILURE
Due to (or es a consequence of): Immediate Cause (Final disease or condition resulting in death) /Medical Examiner / Mouth Examiner physician and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last DUSPHAGIA Box 68760, edical Physician/M 980 Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. 1 Yas 2 No 3 Probably 4 Unknown Congestive hEART MINKE by 24b. Were autopsy findings available prior to 24a. Wes an autopsy performed? Completed completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital 25. Wes case referred to medical examiner? 8 26. Place of Death (Check only one) Hospitel: 1 | Inpatient 2 | ER/Outpatient 3 | DOA | Other: 4 | Nursing Home 5 | Residence 6 | Other Specify | Nursing Home 5 | Residence 6 | Other Specify | Nursing Home 5 | Residence 6 | Other Specify | Nursing Home 5 | Residence 6 | Other Specify | Nursing Home 5 | Residence 6 | Other Specify | Nursing Home 5 | Residence 6 | Other Specify | Nursing Home 5 | Residence 6 | Other Specify | Nursing Home 5 | Residence 6 | Other Specify | Nursing Home 5 | Nursing H 1 Yes 2 No 10 this After this funeral 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? he Hospital or Attending Pin 24 hours efter death.

The Funerel Director: After tolerativ filled in by the funeri Certification: 5 Pending investigation 1 Netural 2 Accident 1 TYes 2 No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 ☐ Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) end menner as stated.

Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, data and place, and due to the cause(s) and manner stated. 29e. Certifier Medical To the Hosp within 24 hor To the Fune completely fi (Check only one) 29d. Date signed (Month, Dey, Year) 290: Signature and the of certific 29c. License number 2000 19252 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) ROBERTO A DEPETRISMD 14300 GALLANT FOXLA# 122 BOWIE MD 2071S

DHMH 16 Rev 6/95

State Registrar 31. Date filed (Month, Day, Year)
JAN 1 4 2000

32. Registrar's Signature

COSS F FAL

Please Type or Print In Black Indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year Physician MARCELO RAYMUNDO JANUARY 10, 2000 10:08pm /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner MONTGOMERY ROCKVILLE SHADY GROVE ADVENTIST HOSPITAL 7. Age (In yrs. last birthday) If Under 1 Year Months Days If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) Birthplace (Stete or Foreign Country) **Funeral** Hours 1 □XM 2 □ F 56 Yrs. Director AUGUST 14,1943 EL SALVADOR **Usual Residence of Decedent** the Manyland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits r than "natural", or flems 23s or 28s-f show MD. MONTGOMERY GAITHERSBURG TY Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 56 WEST DEER PARK ROAD 2087 7 EL SALVADOR Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Rece - American Indian, 11. Marital Status Bleck, White, etc. 72 hours after 1 Yes 27 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 Specify: SALVADORAN 1☐Yes 2☐ No P 3 ☐ Widowed 4 ☐ Divorced HISPANIC Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mentel Hygiene. Important: If them 27 is marked other than *r any injury or other traumatic event, the heal ends. Capitol Landscaping Elementary/Secondary (0-12) College (1-4or 5+) 5th LANDSCAPER Co. 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle Maiden Surname) Be UNK JESUS RAYMUNDO 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) AREGEO SIGUENZA NEPHEW 56 WEST DEER PARK RD. #202 GAITHERSBURG, MD. 20877 20b. Place of Disposition (Name of cametery, cremetory or other place) 20s. Method of Disposition 20c. Location - City or Town, State 1 GBurial 2 Cremation 3 Removal from State SAN SALVADOR, EL 4 Donation 5 Other (Specify) 1/20/00 FAMILY CEMETERY 21. Signature of Funeral Service Licenses 22. Name and Address of Facility W. H. Bacon Funeral Home 3447 14th St. N.W. Washington, D.C. 20010 Bacon CC0361 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Physician + Cerebrovascular Accident /Medical Immediate Cause (Finel disease or condition resulting in death) Examiner Examiner physician and the burief-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 edical Due to (or as a consequence of): Physician/M Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 23b. Did tobacco usa contributa to the cause of death? 1 Yas 2 No 3 Probably 4 Unknown Records. py 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 Ninpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) he Hospital or Attending Physin 24 hours effecteath.
The Funeral Director: After this nates the funeral director of the funeral director. 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending investigation Matural Accident 1∏Yes 2∏No 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 4 Homicide Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) within 2 To the 29c. License number 29d. Date signed (Month, Dey, Year) January 2000 mugn se of death (Num 23a) (Type, Print) Rockville Drive

DHMH 16 Rev 6/95

Registrar

| | 2 | | State of I | Marylar | | | | ealth a Death | and M | | giene 0 0 | 0 | 2365 | |
|---------------------|--|---|---|------------------------------|-------------------------------------|-------------------|--|--------------------------------------|----------------------|--|-------------------------------|-------------------------------------|--|-----|
| | Physician /Medical | 1. Decedent's Name (First, Middle, Las Flora Jannet | | nardso | n | | | | | 2. Date of Dec Month January | Day | Year 0 | 3. Time of Deat 9:41an | |
| | /Medical Examiner | 4e Facility Name (If not institution, give Prince George's | | | ital | | 4 | | wn, or Lo | 2 | Prin | | eorge's | |
| | Funeral Director | 377-32-4112 | ex □M 2 F 7. | Age (In yrs. | last birthday) 5 Yrs. | if Unde Months | Days | if Under Hours | 24 Hrs. Min. | 8. Date of Birt (Month, Da Oct. 31 | , 1934 | 9. Birthe Cour Wash | place (State or Formatry) 1. D.C. | ign |
| | Maryland H show | Usual Residence of Decedent 10a. State 10b. County Maryland Prince G | eorge's | | ty, Town or Lo | | t | | | | | 1 | 0d. Inside City Lin | |
| | a or 28s-f e | 10e. Street and Number 6708 Blacklog St | reet | | | 10f. Z | p Code | 743 | | | 10g. Citizen of V | | | |
| 020 | 72 hours after death with the Maryland natural, or items 23e or 28e-4 show area Examinating an original assets by Funeral Director | 11. Meritel Status 1 Never Merried 2 Merried 3 Widowed 4 Divorced | 12. Wes Decede Armed Force 1 Yes 2 If Yes, Give Year or Date | s? ANo | | | | spanic Ori n, Mexicar Specify: | gin? (Sp , Puerto | ecify Yes or No Ricen, etc.) | Blac | e - Americ ck, White, :: Blac | | |
| Maryland 21215-0020 | within one. | 15. Decedent's Ed (Specify only highest gra Elementery/Secondary (0-12) | lucetion de completed) College (1-4d | or 5+) | | | ual Occupa ork done o use retired Manas | ation furing mosi ger | of work | ing | 16b. Kind of Bu | | dustry | |
| yland; | Mental H Mental H Brked oth atic aven | 17. Fether's Name (First, Middle, Lest) William Waring | | | | | | Cat | heri | ne Smi | | | | |
| | of Health of Health of Health of Health of them 27 is nother trains | Berneta Garrett 20a. Method of Disposition ☆□ Burial 2 □ Cremation 3 □ | / Daught | 20b. I | 11604 Place of Disponentery, cre | 4 Wes | t Bra | anch | Dr. | Upper M | arlboro 20c. Location - | Md . | 20774 own, State | |
| Baltimore, | permit. Peg Department Important: if eny lnjury o once. | 4 Donation 5 Other (Specify 21. Signature of Funeral Service Licen | | 185 | 2 | Alexa | nd Addres | ssof Facili | ŏpe | /10/00 Funeral | Homes | | 20747 | |
| | Physician /Medical Examiner | 23a. Part1. Enter the dealer, or companies, or heart terms. Lest only Immediate Cause (Final disease or condition resulting in death) | cations thet causone cause on eech | nce | th. Do not en | ea | lie | g, such as | cardiac | or respiratory e | rrest, | | Approximate Interval Between Onset and Deeth | |
| 8760, | death certificate be executed e ettending physician and of for use as the burial-transit sician/Medical Examiner | Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events | b | | or es a conse | | | | | | | 1 | | |
| Box 687 | eath certificate ettending phy: | resulting in death) Last | d | Due to (d | or as a conse | quence of | : | | | | | | | |
| P.0. | ed by the detache | Part II. Other significant conditions of | ontributing to deat | n but not res | sulting in the t | underlying | ceuse giv | en in Part I | • | 23b. Dld | | | the cause of de bebly 4 Unki | |
| Records, | aw requiras is been sign 2 should be pleted by | | | | Ber | | | | | 24a. Was perfo | an autopsy ormed? | av | ere autopsy findin ailable prior to impletion of ceuse death? | |
| Vital R | certificate he rector, page | 25. Was case referred to medical | | | | | | 26 Place | of Deet | 1 ☐ 1 | | 11 | Yes 2□No | |
| o | hys his I di | examiner? 1 | | | ER/Outpatie | of | 28c. Injur | er: 4□ Nu y at k? | irsing Ho | ome 5 Resi | dence 6 Oth | | (y) | |
| Division | C 0 6 | 2 Accident investigation 3 Suicide 6 Could not be determined | 28e. Piace of | Injury - At h etc. (Speci | nome, farm, si | M reet, facto | | Yes 2□ | NO | 28f. Location (City or To | Street and Numb wn, State) | per or Run | al Route Number, | |
| | in 24 hours in 24 hours he Funer pletely fill edical | 29a. Certifier (Check only one) Cartifying Ph | ysician: To the be niner: On the basis and manner | s of examina | owiedge, deel ation and/or Ir | vestigatio | n, in my o | pinion, dea | d piece, th occur | end due to the red at the time, | date and place, | and due t | o the cause(s) | |
| | To the within com | 29b. Signefure and fille of certifier | e | - 1 | ME | 7 | Oc. Licens | s number | 3/ | 8- | 29d. Date sign | 5/ | O D | |
| | (10) | 30. Name and address of person who ANTERSEN M. 31. Date tiled (Month, Dey, Year) | D. 3001 I | | CAL DR. | | VERLY | ,MD | 2078 | 5 | / | ′ | | |
| | State Registrar | IAN 1 2 2000 | A | مصمم | 1 | 10 | als | 1 | | | | | | |

MAN I 2 2000 James of the State
| | 1 | . Decedent's Name | a (First. Mide | dla, Last) | | | | rtificate of | Dodin | | 2. Data of D | Reg. No. | | 3. Time of Dea |
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| aminer | | 19A Hil | | | | | | | Gree | | | | | |
| neral | 5. | . Social Security N | | 6. Sex | | 7. Aga (In yr | s. lest birthday) | If Under 1 Year | If Under 2 | 24 Hrs. | 8. Data of B (Month, D | irth | | eorge's hplace (Stata or Fo |
| ctor | | 235-66-5 | 9/10 | 1 X | M 2□F | 59 | Yrs. | Months Days | Hours | Min. | | 2, 1940 | | _{untry)} t_Virgini |
| rector | | Jsual Rasidanca of | Decadant | | | | | | | | Aug. 1 | , 1270 | MED | |
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| Directo | 1 | 0e. Street and Nur | mber | | | | | 10f. Zip Coda | | | | 10g. Citizen | of What Co | untry? |
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| Funerai | 1 | 1. Marital Status | W. | | Armed F | | U,S. 13. | Wes Decedant of If Yes, specify Cub | Hispenic Origon, Mexican | gin? (Spe , Puerto | cify Yes or N Rican, atc.) | 0- 14. F | lace - Amai lack, White | rican Indian, a, atc. |
| by F | | 1 Navar Marri | | | If Yes, G | 24 No | | 1□ Yas 2HNo | Specify: | | | Spe | city: Wh | ite |
| | | 3 LI WIGOWAG | 15. Deceda | | Yaar or [| Datas. | 16a Dece | dant's Usual Occu | nation | | | 16b. Kind of | | |
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| ToB | 2 | | Unknov | רוע | | | | | Ann | M. F | Rakowsl | ci | | |
| - | | 19a. Informant's Na | | | pe, Print) | | 19b. Maili | ng Addrass (Strea | | | | | vn, State, Z | Zip Code) |
| - 500G | | Judith C | . Pear | rson | /wife | | 19 | A Hillsi | de Roa | ad | Green | nbelt, | MD 2 | 0770 |
| | 2 | Oa. Mathod of Disp | | | | 20b | Place of Dispo | osition (Neme of matory or other ple | ace) | 1 | Data | 20c. Locatio | n - City or | Town, Stata |
| | | 1 ☐ Buriel 2N 4 ☐ Donation | | | amovel from | Stata | | ematory | , | 1 | 5/00 | Waldor | f. Ma | rvland |
| * | 2 | 21. Signature of Fa | | | VI |) " | | 2. Name and Addr | | У | | | | Lyland |
| PDC | | 1 tot | 18 | N | ill | 10.0 | | Robert | | | | _ | | 00715 |
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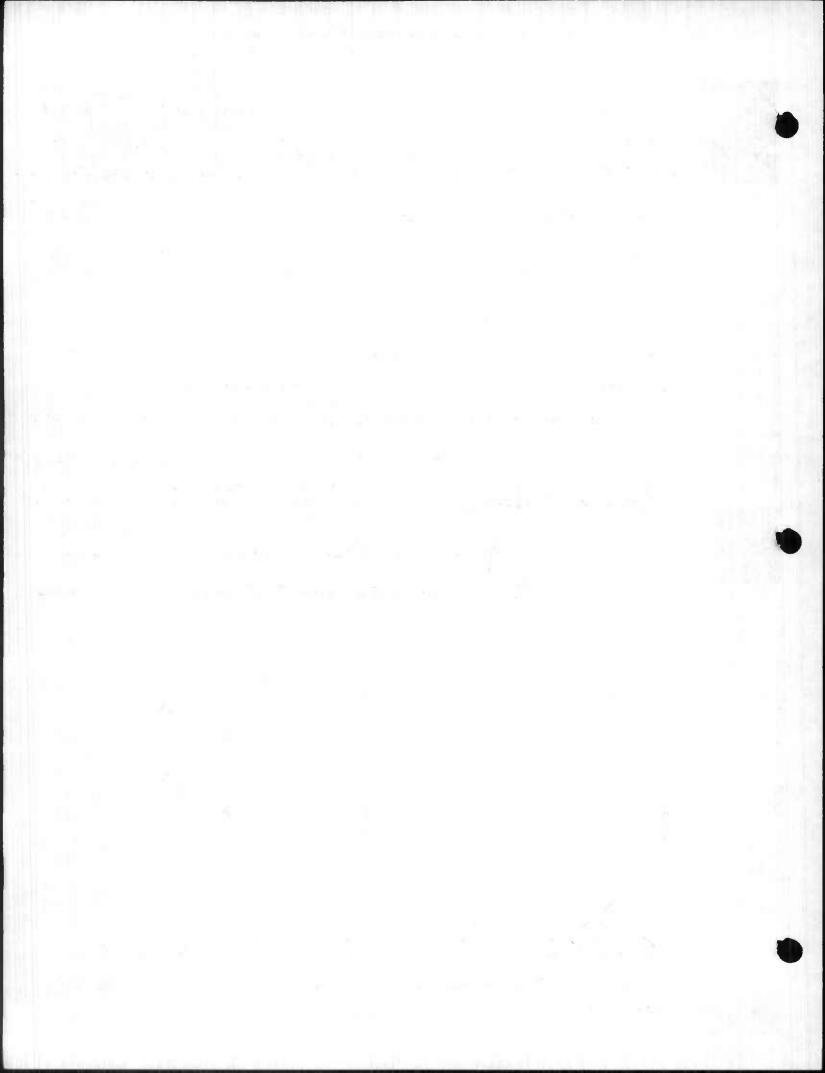
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 9200 PM JANUARY 200C Eleanor Mary Rose /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Doctor's Community Hospital Prince George's Lanham If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min. 10 M 2X F Months Days Hours 213-42-9416 88 Director Maryland Usual Residence of Deceden 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Maryland Prince George's Glenn Dale 1X Yes 2 No Director 10e. Street and Number 10f. Zip Code 10c. Citizen of What Country? 12017 Fairway Court 20769 U.S.A. Nems 23a 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien. 11. Marital Status Bleck, Whita, etc. 7 is marked other than "natural", or iter traumatic event, the Medical Examinar 1 Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White þ 3 Ø Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) City of Bowie 12 Secretary Commit. Pages 1 and 2 should be file beconstructed of the marked other law and Merical Hys improvement if them 27 is marked other any injury or other treamest. 18. Mother's Nama (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Jacob Seitz Nannie Reum 19a. Informant'a Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Coda) Jane L. Piper, Daughter 12017 Fairway Court, Glenn Dale, Maryland 20769 20a. Method of Disposition 20b. Place of Disposition (Name of cemetary, crematory or other place) 20c. Location - City or Town, Stete Data 1 Burial 2 Cremetion 3 Removel from State Metropolitan Crematory 1/7/2000 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Addrass of Fecility 21. Signature of Funeral Service Licensee Gasch's Funeral Home, P.A., 4739 Baltimore Avenue, Hyattsville, MD 20781 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximata Intervel Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical 30/20 DIYNA Examiner Due to (or as a consequence of): Examiner physician and the buriel-transit The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) 68760 Physician/Medical that initiated events resulting in death) Last Due to (or as e consequence of): Box P.0. Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 1 Yea 2 No 3 Probably 4 Unknown Records, by 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed Dege 2 1 Yes 2 No 1 TYes 2 No certificate of Vital 25. Was case referred to medicat examiner? Be 26. Place of Death (Check only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 0 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of tnjury (Month, Day Year) 28d. Describe how Injury occurred Certification: 28c. Injury et Work? Division Attending 5 Pending investigation 1 Natural deeth. 1 Yes 2 No 2 Accident Director: / 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 3 Suicide 6 Could not be 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) To the Hospital or A within 24 hours after To the Funeral Direct completely filled in by efter 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data end place, and dua to the causa(s) and mannar as stated.
2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at tha time, data and place, and dua to the causa(s) and manner stated. edical 29a. Certifier 29b. Signature and title of certifier 29c. License number 45660 MD 6 00 UN Sulo 124, Bocie MD 22715 30. Name and address of person who completed cause of death (frem 23a) (Type, Print) 14300 AN tex 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2000 Registrar

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedant's Nema (First Middle Last) 2. Data of Death 3. Time of Death **Physician** Month Anna Runvon January 16 2000 2042 P /Medical 4a. Facility Nema (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 96 Murray Road Elkton Cecil 5. Sociel Security Number If Under 1 Year f Under 24 Hrs. Hours Min. 7. Age (In yrs. last birthday). Funeral Birthplaca (Stata or Foreign Country) 1 M 2 XF 234-68-1787 Yre Director January 23, 1913 West Virginia Usual Rasidanca of Dacadent with the Meryland 10a. Slata 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2X No Director Maryland Cecil Elkton 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 96 Murray Road 21921 Нета 23а United States Funeral 12. Wes Dacedant Evar in U,S Armed Forcas? Was Dacedant of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuben, Maxican, Puerto Rican, atc.) 14. Rece - Amarican Indian, Black, Whita, atc. 11. Marital Status Peges 1 and 2 should be filed within 72 hours efter neat of Heelih and Mentel thygiene. In: If Item 27 is marked other than "natural", or item Iny or other traumatic event, the Medical Entanniary or other traumatic event, the Medical Entanniary. 1 ☐ Yas 2 ☒ No If Yas, Giva Year or Dates: 1 ☐ Nevar Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☑ No Specify. by Specify: 3 X Widowad 4 Divorced White Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa retired) 15. Dacadant's Education (Specify only highast grade completed) 16b. Kind of Businass/Industry Elementery/Secondary (0-12) Collage (1-4or 5+) In her own home 8 Homemaker 17. Fethar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maidan Sumama) Be Floyd Curry Sarah Jane Carey 19e. Informant's Name/Reletionship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Lorraine Hastings/Daughter 20 Locust Road, Cooper Farms, Wilmington, DE 19808 20b. Place of Disposition (Nama of comatary, cramatory or other pleca) 20c. Location - City or Town, Stata 1 Buriai 2 Cramation 3 Removel from Stata 4 Donation 5 Other (Specify) permit. Pege Department of Important: If sny injury or Gracelawn Memorial Park 1/22/2000 Wilmington, Delaware 21. Signatura of Funeral Sarvica Licanses 22. Nama and Addrass of Facility Hicks Home for Funerals, P.A. clas 103 West Stockton Street, Elkton, Maryland 21921 id 23a. Perf1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Batween Onset end Death **Physician** /Medical immediata Causa (Final UTE MYOCARDAL disaasa or condition rasulting in death) **Examiner** Examiner terioscleratio physician end s the bunal-trensit The law requires that the death certificate be executed Sequantially list conditions, if eny, leading to immadiata causa. Entar Undarlying Cause (Disease or Injury that initiated avants resulting in death) Last P.O. Box 68760, Physician/Medical Dua to (or as a consequence of) 82 sate has been signed by the ettending page 2 should be detached for use as Pert ii. Other aignificent conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of deeth? 1 □ Yee 2 No 3 Probably 4 ☐ Unknown Records, þ Completed 24b. Were autopsy findings aveilable prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 Yes 1 ☐ Yas 2 ☐ No certificate Division of Vital Hospital or Attending Physician: 24 hours after death.
Funeral Director: After this certifica etely filled in by the funeral director, p Be 25. Wes casa rafarrad to medical 26. Pleca of Death (Check only ona) axeminar? Other: 4 Nursing Homa 5 Rasidance 8 Other (Specify) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Yas 2□ No Certification: To 27. Mannar of Death 28e. Deta of Injury (Month, Day Year) 28b. Tima of 28c. Injury et Work? 28d. Dascribe how Injury occurred 1 Naturel 2 Accident 5 Panding invastigation 1 ☐ Yas 2 ☐ No 6 Could not be determined 3 Suicida 28a. Place of injury - At home, farm, streat, factory, office building, atc. (Specify) 28f. Location (Streat and Number or Rural Route Number, City or Town, Stete) 4 Homicida To the Hospital within 24 hours a To the Funeral C 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner states. Medical 29a. Cartifier 29b. Signature apetition contino 29c. License number 29d. Date signed (Month, Day, Year) 30. Nama and address of person who completed cause of daath (Item 23e) (Type, Print) ROSENBAUM
32. Registrar's Signature Robert 300 BOW Street Elkton MD 2192) Doctor 31. Date filed (Month, Day, Year) State JAN 1 8 2000 Registrar



| sician | 1. Decedant's Nama (First, Middla, Last) | | Certificate | 9 01 | D Catir. | 2. Dete of Dea | Reg. No. | | 3. Time of Death |
|-----------------------------|---|--|--|---------------------|---|--|--|--|-----------------------------------|
| | | | | | | JAN. 1 | 2000 | Yaer | 0715 |
| edical | ISAIAH W. ROLI 4a Facility Nama (If not institution, giva | | | | 4b. City, Town, or L | | | of Death | 0713 |
| miner | An and the second second | DICAL CENTER | | | ANNAPOLI | | ANNE | | EL |
| ral | 5. Sociei Security Number 6. Sec | 7. Aga (In yrs. last | t birthdey) If Under | 1 Yaar | If Undar 24 Hrs. | 8. Data of Birt (Month, De) | | 9. Birtholad | a (Stata or Foraign |
| tor | 213-28-3515 | ^{tM 2□ F} 68 | Yrs. Months | Deys | Hours Min. | MAY 24 | 1931 | MARYI MARYI | AND |
| | 10a. State 10b. County | 10c. City, T | Town or Location | | | | | 10d | . Insida City Limits |
| leted by Funeral Director | MARYLAND ANNE A | RUNDEL ODEN | NTON | | | | | | XYas 2□No |
| Director | 10e. Street and Number | | 10f. Zip | Coda | | | 10g. Citizan of V | Vhat Country | ? |
| 2 | 2987 CONWAY RO | | 2111 | | | | | USA | |
| by Funeral | 11. Marital Status 1 Navar Marriad 2 Married 3 Widowed 4 Divorced | 12. Was Decedent Ever in U.S. Armed Forces? 1∑ Yas 2☐ No If Yas, Giva Yaar or Datas:1955—5 | If Yes, spec | ify Cub | Hispanic Origin? (Sp an, Maxicen, Puarto Specify: | ecity Yes or No- Ricen, atc.) | | e - Amarican k, Whita, ato BLAC | 2. |
| ted | 15. Decedent's Edu (Spacify only highest grade | | 16a. Decedant's Usua | l Occup | pation | ina | 16b. Kind of Bu | siness/Indus | stry |
| Completed | Elemantary/Secondary (0-12) | Collega (1-4or 5+) | | | during most of work d) | | | | |
| Co | 7th 17. Fathar's Nama (First, Middle, Last) | 0 | CONSTRUC | CTI | - | a (First APA) | RAY SE | | CONSTRUCT |
| Be | 17. Fathar's Nama (First, Middle, Last) james b. re | ollins | | | 18. Mothar's Nem | e (First, Middle, E E . G | | a) | 101 |
| 2 | 19e. Informent's Neme/Relationship (Ty | | 19b. Malling Addrass | (Street | | | | State 7in C | ode) |
| | | | | | | | 01 | | |
| | BESSIE QUEEN (N. 20a. Mathod of Disposition | 20b. Plec | 2975 CONI be of Disposition (Nan latary, cramatory or of | na of | | Data Data | MD 21 | 113 City or Towr | n, Stata |
| | 1) ☐ Burlel 2 ☐ Crametion 3 ☐ R 4 ☐ Donetion 5 ☐ Othar (Specify) | emoval from Stata | YLAND VE | | | 16/200 | O CROW | INSVII | LLE, MD. |
| | 21. Signeture of Funaral Sarvice Licans | | 22. Nama an | | | 1/0/201 | O CROW | MDATI | Juli, MD. |
| | 1-1 H.D. | | | EES | | | JARY, P | | |
| | 23a. Pert1. Entar tha disaasa, or compl | cations that ceused the death. | 821 W Do not antar the mod | EST e of dyi | ST. ANI | or raspiratory ar | rast, MD. | 2140 | pproximete ntarvai Batween |
| | shock, or haart failura. List only or | ne causa on each line. | | | | | | C | Inset and Death |
| | Immadiata Causa (Finat disease or condition | NECROTIT | RING PN | 5,00 | nonia | | | 0 | SE WELL |
| | rasulting in daath) | | s a consequence of): | | | 1 - 1 - 4 | | | Masies 30 |
| in in | | DYSFUNG | MONAL | | Swall | Juno 1 | - | 6 | Mastas |
| edical Examine | Sequentially list conditions, if any, taeding to immadiata ceuse. Enter Undarlying | Due to (or e | s e consequence of): | | | | | | |
| ai E | Cause (Disaasa or Injury | | | | | | | | |
| edic | that initiated events resulting in death) Last | Dua to (or as | s a consequance of): | | | | | 1 | |
| 1 | | d | | | | | | 1 | |
| icia | Part II. Other significant conditions cor | tributing to death but not resulting | ng in the underlying o | ause oi | van In Part I. | 23b. Did 1 | lobacco use co | ntribute to ti | he cause of death? |
| Physician/M | | | ar are enoughing of | A. | | 1 🗆 | 3.4 | | bly 4 Unknown |
| | SCHIZOPI | 428410 | | | | | | | |
| 0 | | | | | | 24a. Was | an eutopsy | avalle | autopsy findings obla prior to |
| ted b | | | | | | | | comp of da | pletion of cause ath? |
| pleted b | | | | | | | 14 | 10 | ras 2□ No |
| Completed b | | | | | | 101 | ras 2000 | | |
| Be Completed by | 25. Was cesa rafarred to madicel axeminar? | | | 1 | 26. Placa of Daa | | | | |
| To Be | axeminar? | | VOutpatient 3□ DO | A | her: 4 Nursing H | th (Check only o | ina) dence 6 Oth | | |
| To Be | axeminar? 1 Yas No 27. Mannar of Death 1 Netural 5 Pending | 28a. Deta of Injury (Month, Day Year) 28 | Bb. Tima of 2 | 8c. inju Wo | her: 4 Nursing Hery at rk? | th (Check only o | na) | | |
| To Be | axeminar? 1 Yas No 27. Manner of Death 1 Neturai 5 Pending 2 Accident Invastigation | 28a. Deta of Injury (Month, Day Year) | Bb. Tima of 2 Injury M | 8c. inju Wo | her: 4 Nursing H | th (Check only coma 5 - Rasicoma 28d. Dascribe i | ona) dence 6 ⊟Oth now Injury occurr | red | 20110 Number |
| To Be | axeminar? 1 Yas No 27. Manner of Death Neturai 5 Pending 2 Accident Invastigation | 28a. Deta of Injury (Month, Day Year) 28 | Bb. Tima of 2 Injury M | 8c. inju Wo | her: 4 Nursing Hery at rk? | th (Check only coma 5 - Rasicoma 28d. Dascribe i | dence 6 Other | red | Routa Number, |
| Certification: To Be | axeminar? 1 | 28a. Deta of Injury (Month, Day Year) 28a. Place of trijury - At home building, atc. (Specify) | Bb. Tima of lnjury M B, farm, street, factory | 8c. Inju Wo 1 | her: 4 □ Nursing H ry at rk?] Yes 2 □ No | in (Check only of oma 5 Residue) 28d. Describe I 28f. Location (City or Tow | dence 6 □Oth- now Injury occurr Streat end Numb | red er or Rural f | |
| Certification: To Be | axeminar? 1 Yas No 27. Mannar of Death 1 Neturai 5 Pending Invastigation 2 Accident Invastigation 3 Sulcida 6 Could not be datarmined 29a. Certifiar Certifying Physics | 28a. Deta of Injury (Month, Day Year) 28a. Place of Injury - At home | Bb. Tima of Injury M e, farm, street, factory | 8c. Inju Wo | her: 4 Nursing H ry at rk? Yes 2 No | th (Check only of oma 5 Residence 1 Reside | dence 6 Oth- now Injury occurring. | red er or Rural f | ød. |
| To Be | axeminar? 1 Yas No 27. Manner of Death 1 Neturai 5 Pending Invastigation 3 Sulcida 6 Could not be datarmined 29a. Certifiar (Check only) 2 Modicai Examin | 28a. Deta of Injury (Month, Day Year) 28a. Place of Injury - At home building, atc. (Specify) alcian: To the best of my knowle her: On the basis of axamination | Bb. Tima of Injury M Be, farm, street, factory adge, deeth occurred in and/or Invastigation, | 8c. inju Wo | her: 4 Nursing H | th (Check only of oma 5 Restormed 28d. Describe In City or Towns and due to the tree et the time, | dence 6 Oth- now Injury occurring. | er or Rural F annar as stat and due to th | ed. as ceuse(s) |
| edical Certification: To Be | axeminar? 1 Yas No 27. Manner of Death 1 Noturai 2 Accident 3 Sulcida 4 Homicide 29a. Certifiar (Check only one) | 28a. Deta of Injury (Month, Day Year) 28a. Place of Injury - At home building, atc. (Specify) alcian: To the best of my knowle her: On the basis of axamination | Bb. Tima of Injury M Be, farm, street, factory adge, deeth occurred in and/or Invastigation, | 8c. inju Wo | her: 4 Nursing H | th (Check only of oma 5 Restormed 28d. Describe In City or Towns and due to the tree et the time, | dence 6 Oth- now Injury occurrence Streat and Numb vn, State) cause(s) and ma date and place, 29d. Data signare | red er or Rural F annar as stat and due to the | ed. na ceuse(s) ny, Year) |
| edical Certification: To Be | axeminar? 1 Yas No 27. Manner of Death 1 Noturai 2 Accident 3 Sulcida 4 Homicide 29a. Certifiar (Check only one) | 28a. Deta of Injury (Month, Day Year) 28e. Ptace of Injury - At home building, atc. (Specify) alclan: To the best of my knowle her: On the basis of axamination and mannar stated. | Bb. Tima of Injury M Be, farm, street, factory adder, deeth occurred in and/or Invastigation, | 8c. inju Wo | me, date and place, opinion, daath occurse number | th (Check only come 5 Residue) 28d. Dascribe I 28f. Location (City or Town and due to the acred et the time, | dence 6 Other own Injury occurrence of the stream of the s | er or Rural F | ed. na ceuse(s) ny, Year) |
| edical Certification: To Be | axeminar? 1 Yas No 27. Manner of Death 1 Neturai 2 Accident 3 Sulcida 4 Homicide 29a. Certifiar (Check only one) 29b. Signal as and tills of certifier | 28a. Deta of Injury (Month, Day Year) 28a. Place of Injury - At home building, atc. (Specify) alcian: To the best of my knowle her: On the basis of axamination and mannar stated. | Bb. Tima of Injury M Be, farm, street, factory adder, deeth occurred in and/or Invastigation, | 8c. inju Wo | me, date and place, opinion, daath occurse number | th (Check only come 5 Residue) 28d. Dascribe I 28f. Location (City or Town and due to the acred et the time, | dence 6 Other own Injury occurrence of the stream of the s | er or Rural F | ed. na ceuse(s) ny, Year) |

MAN O E 2008

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Deta of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month 9:06pm Cliff January 3 2000 R. Roop 4b. City, Town, or Location of Deeth 4c. County of Deeth 4e Facility Neme (If not institution, give street end number) Anne Arundel Medical Center Anne Arundel Annapolis If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 ☐ M 2 ☐ F Deys Yrs. 45 228-74-8274 8/25/1954 Virginia Usuei Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Anne Arundel Severna Park 10e Street and Number 10f. Zip Code 10g. Citizen of Whet Country? Blenheim Ct. 21146 USA 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Stetus Bleck, White, etc. 1 Yes 2 No If Yes, Give X Yeer or Detes: 1 Never Married 2 Married 1□ Yes 2□No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuet Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elamentery/Secondary (0-12) Coitege (1-4or 5+) Owner Auto Service Station 18. Mother's Neme (First, Middle, Meiden Surname) 17. Fether's Neme (First, Middle, Last) Frederick Clyde Roop, Sr. Nola Harris 19e. Informent's Name/Retetionship (Type, Print) 19b. Melling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) ex-wife 1641 Allen Circle Bethlehem PA 18017 Lynnell Leighty Roop 20b. Plece of Disposition (Neme of cemetery, cremetory or other pleca) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 Deurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 1/8 Mount Comfort Cem. Fairfax, VA fature of Scheral Segue Ligense 22. Neme end Address of Fecility Barranco & Sons PA Severna Park FH 495 Ritchie Hwy. Severna Park MD ... Enter the disease, or complications that caused the deeth. Do not enter the moda of dying, such as cardiec or raspiretory arrast, frock, or heart feilure. List only one cause on each time. 21146 Approximata Intervei Between Onset end Deeth Vascular Disease Immediate Cause (Finel Cardinabeular. UNKNOWN diseese or condition resulting in death) Sequentially list conditions, if eny, leading to immediate cause. Entar Underlying Cause (Disaesa or injury that initiated events resulting in deeth) Lest Due to (or es a consequença of): Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Wera autopsy findings aveilable prior to 24e. Wes an eutopsy performed? completion of cause of death? 2 7 No 1 Yes 2 No 1 Yes 26. Place of Deeth (Check only one)

Physician /Medical Examiner

certificete be exec

P.0.

Division of Vital Records.

or Attending Physician:

Hospital

the

0

within 24 hor To the Fune completely fi

permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is m any Injury or other traum once.

Physician

/Medical

Examiner

Director

Funeral

Q

Completed

790

Funeral

Director

Hem 27 is marked other than "natural", or Hems 23s or 28s-1 show other traumetic event, the Medical Examinar must be notified at

2 should be filed within 72 hours after death and Mental Hygiene.
Is marked other than "natural", or items 23.

altimore, Maryland 21215-0020

with the Maryland

attending physician and for use es the bunal-tran signed by t d be detach hes page 2

Examiner Physician/Medical by Completed funeral director Be 2 After this Certification: 24 hours after death. Funeral Director: Af

28e. Dete of Injury (Month, Dey Year)

25. Wes casa rafarred to medicat exeminer?

1 ☐ Inpatient 2 ER/Outpatient 3 ☐ DOA

28e. Piace of tnjury - At homa, farm, streat, fectory, office building, etc. (Specify)

28b. Time of

Other: 4 Nursing Home 5 Rasidance 8 Other (Specify)

28d. Describe how Injury occurred 1 Yes 2 No

28f. Location (Street end Number or Rural Route Number, City or Town, State)

Cartifying Physician: To the bast of my knowledge, deeth occurred et the time, date end place, and dua to tha cause(s) and mannar es stated.

2 Medical Examiner: On the basis of examination end/or invastigation, in my opinion, daeth occurred et the tima, dete end piece, and due to the cause(s) end menner steted. 29a. Certifian (Check only one)

investigation 6 Could not be datarmined

5 Panding

1 ☐ Yes 2 No

27. Menner of Deeth

1 Naturai 2 Accident

3 ☐ Suicide

4 T Homicide

29c. License number

28c. Injury et Work?

29d. Dete signed (Month, Day, Year) 4100

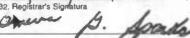
30. Name end eddress of person who complated cause of daeth (ttem 23a) (Type, Print)

DEN, M.D., 600 RIDGELY AVE., ANNAPOLIS, ND
32. Registrar's Signatura SOOT 31. Dete filed (Month, Dey, Year)

State Registrar

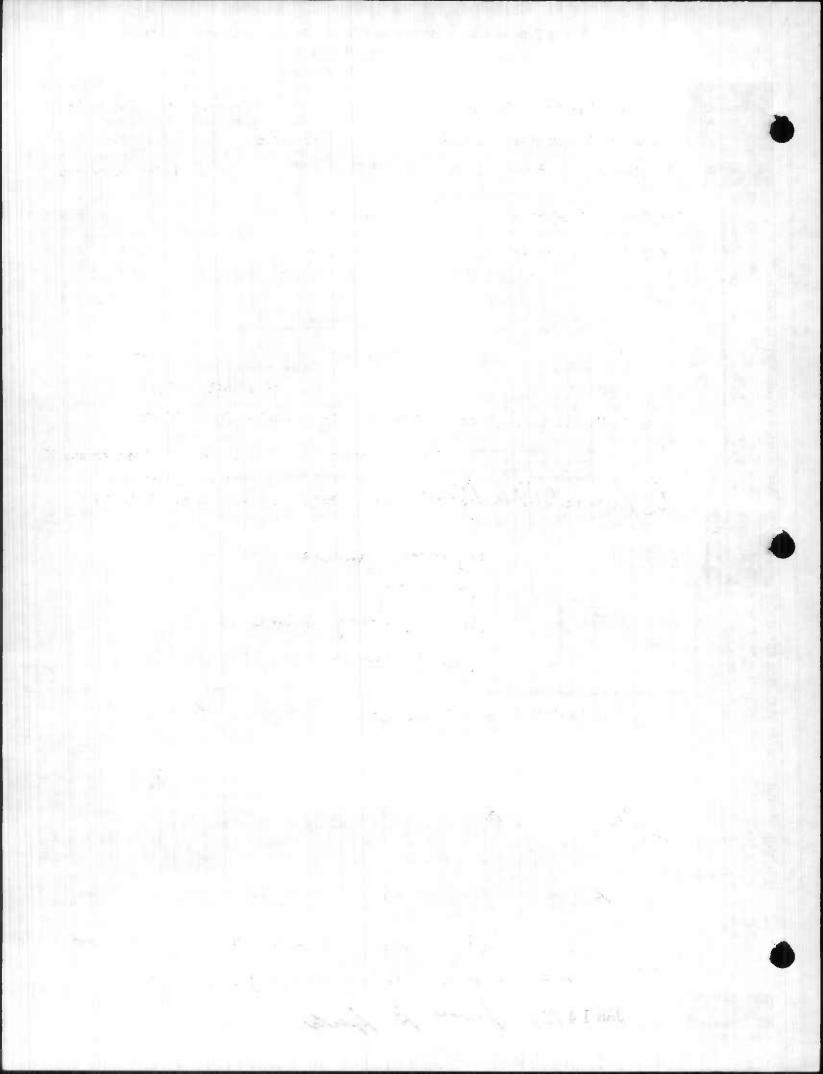
edical

JAN 0 5 2000



State of Maryland / Department of Health and Mental Hygiene

| | | | | | rtificate of | Death | R | eg. No. | U | 6311 |
|--|---|--|--|---------------------------------------|--|--|---|-------------------------|-----------------------------------|---|
| | Physician | 1. Decedent'a Name (First, Middle, Last | | | | | 2. Data of Deat Month | Day | Year | 3. Time of Death |
| | /Medical | Irene Mildred | | | | | January | | 2000 | 2:00AM |
| . E | Examiner | 4a Facility Name (If not institution, give | | 1 | | 4b. City, Town, or Lo | cation of Death | 4c. County | | |
| | | Frederick Memor | • | | In the second second | Frederick | P. Date of Birth | | erick | |
| | uneral rector | 5. Social Security Number 214-14-6020 Usual Residence of Decedent | x 7. Age (in) | yrs. last birthday) 4 Yrs. | Months Days | House Min | 8. Date of Birth (Month, Day, Nov. 6, | 1925 | 9. Birthpi Count Mary | lace (State or Foreign try) y land |
| land | e ta | 10a. Stata 10b. County | 10c. | City, Town or Lo | ocation | | | | 10 | Od. Inside City Limits |
| Mary | to to | Maryland Freder | rick | Wo | oodsboro | | | | | 12 Yes 2 □ No |
| h with the | r items 23s or 25s-fs area mant be noursed Funeral Director | 10e. Street and Number 635 W. Adams Cir | cle | | 10f. Zip Code 217 | 98 | 1 | 0g. Citizan of V U.S | | try? |
| 5-0020 72 hours efter death with the Maryland | o o | 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. Was Decedent Ever I Armed Forces? 1 ☐ Yes 2 Ñ No If Yes, Give Year or Dates: | | Was Decedent of H If Yas, specify Cub 1 ☐ Yes 2 ☒ No | Hispanic Origin? (Spe an, Mexican, Puerto Specify: | ecify Yas or No- Rican, etc.) | Biad | e-America ck, White, e Whit | etc. |
| | nt, the Medical Ex- | 15. Decedent's Edu (Specify only highest grad Elamantary/Secondary (0-12) | cation le complatad) College (1-4or 5+) | | dent's Usuel Occup kind of work done DO NOT use ratire | oation during most of working d) | ng | 16b. Kind of B | n hom | |
| d 2 Hygie | | 17. Father's Name (First, Middle, Last) | | 110 | memaker | 18. Mother's Name | (First, Middle, I | | | ie |
| la be | | Al G. Wroten | | | | Sadie | Emily V | Wright | | |
| Maryland d 2 should be file | EE | 19a. Informant's Name/Relationship (T) | vpe, Print) | 19b. Maili | ng Address (Street | and Number or Rura | | | State, Zip | Code) |
| | 27 ls r tra | Patricia Wheeldon | / daughter | P.O. | Box 3073 | 3 Freder | ick, MD | 21705 | | |
| of H | int: If item 2 iry or other | 20a. Method of Disposition 1% Burial 2 Cremation 3 4 Donation 5 Other (Specify) | Removal from State | | osition (Nama of matory or other pla Cemetery | се) | | 20c. Location - | | own, State |
| Baitim permit. Pag | Important: eny Injury pnce. | 21. Signature of Fyneral Sarvice Licens | . Wartso | . / | 2. Name and Addres | in St | tzler Fi | | | |
| | | 23a. Part1. Enter the disease, or comp shock, or heart failure. List only o | ications that causes the c | | | | | | 21790 | Approximata Interval Between |
| /Me Exar | edical miner Examiner | Immediate Causa (Final diseese or condition resulting in daath) | b. pre | om an u | | ما | | | | Onset and Death |
| W # | J by the attending physician and elached for use as the bunel-transit Physician Additional Examir | Sequentially tist conditions, if any, teading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last | c. Chron | o (or as a consec | morany | disease | | | 1 | |
| , Box | e atte | Part It. Other significant conditions co | ntributing to death but not | resulting In the u | inderlying cause gir | ven in Part I. | 23b. Dld to | obacco use co | ntribute to | the cause of death? |
| P.O. | | wetasta | tic breast | cance | 25 | | 1/20 | /es 2□ No | 3 Prot | bably 4 Unknow |
| Sords | should be | | | | | | 24a. Was a perform | an autopsy med? | ava | ara autopsy findings ailabia prior to mptation of cause death? |
| Re la | page 2 | | | | | | 1 T Y | es 2 No | |]Yas 2□ No |
| | certificate rector, par | 25. Was casa rafarred to medical | | | | 26. Place of Death | (Check only or | nal | | 3 140 |
| on of Vita | T di | examiner? 1 Yes No 27. Nanner of Death 1 Natural 5 Pending 2 Accident investigation | lospitat: 1 Inpatient 28a. Date of Injury (Month, Day Yea | 2 ER/Outpatie 28b. Time of Injury | 1 28c. Inju | her: 4 Nursing Ho | | ance 6 Ott | | v) |
| Division of Attending after death. | al Director: After to the in by the funeral Certification: | 3 Suicide 6 Could not be 4 Homicide datarmined | 28e. Placa of Injury - / building, etc. (Sp | At home, farm, st ecify) | reet, factory, office | | 28f. Location (S City or Tow | | ber or Rura | I Route Number, |
| the Hospital | Funer stely fill dical | 29a. Certifier Certifying Phy (Check only one) | sicten: To the best of my ner: On the basis of exam and manner stated. | knowledge, daat nination and/or in | h occurred at the ti vestigetion, in my | me, dete and place, opinion, death occurr | end due to the c ed at the time, d | ause(s) and made, | anner as st and dua to | tated. the cause(s) |
| To the within | To the con | 29b. Signatura and titla of certifier | 1 til | M | 29c. Licent | sa number) 53 (2 | 9 | 29d. Date signe | d (Month, | Day, Year) |
| | | 30. Nama and addrass of person who co | ompleted causa of death | (ttam 23a) (Type, | Print) Cope | ermine R | H. POF | Box6 | | |
| | State Registrar | 31. Date filed (Month, Day, Year) | 32. Ragistrar's S | | readsbore | , mo a | | | | |



| | | | | Cei | rtificat | e or | Dealli | | F | leg. No. | | 02.07 |
|-----------------------|---|--|---|--------------|--------------------|----------------|----------------------|---------------|------------------------------|--------------------|---------------------------------|---|
| | 1. Decedent'a Neme (First, Middle, La | ast) | The second | | | | 111 | 2 | 2. Dete of Dee Month | th Day | Year | 3. Time of Dea |
| an al | Carolyn R | Shumate | 9 | | | | | ٠ | Jan | | 2000 | 9:20 |
| er | 4a Facility Neme (If not institution, gi | ve street end number) | | | | 4 | 4b. City, Tov | vn, or Loca | ation of Deeth | 4c. County | of Deeth | |
| н | 215 Garden Wa | ау | | | | | | mins | | | arro | 11 |
| | | Sex 7. Ag | ge (In yrs. las | | If Under Months | 1 Yeer Deys | If Under 2 Hours | Min. | Date of Birth (Month, Dey | Year) | 9. Birthp Coun | lace (Stete or Fo |
| | 216-56-7743 | 10 W 2021 | 53 | Yrs. | | | | (| oct 7 | 1946 | | MD |
| 1 | Usuel Residence of Decedent 10a. Stete 10b. County | | 10c. City, | Town or Lo | cation | | | | | | 1 | 0d. inside City L |
| 0 | MD Carro | 211 | We | stmi: | nste | r | | | | | | 11 Yes 2 |
| 5 | 10e. Street end Number | <i>y</i> === | 1 | - | 10f. Zip | | | | | log. Citizen of | What Coun | try? |
| Funeral Director | 215 Garden Way | s.r | | | 2 | 115 | 7 | | | USA | | |
| era | 11. Meritel Stetua | 12. Wes Decedent | | 13.1 | | - | 1 | in? (Spec | ity Yes or No- can, etc.) | | e - Americ | |
| 5 | 1 Never Merried 2 Married | Armed Forces | | | | | | , Puerto Hi | can, etc.) | | ck, White, | etc. |
| 5 | 3⊠Widowed 4 □ Divorced | If Yes, Give Yeer or Detes: | | | 1 Li Yes | ZYLI NO | Specify: | | | Specif | Wh | ite |
| | 15. Decedent's E (Specify only highest gr | | | 16e. Dece | dent's Usua | el Occup | etion during most | of working | 7 | 16b. Kind of B | usiness/Ind | dustry |
| Completed | Elementery/Secondery (0-12) | College (1-4or | 5+) | life. | DO NOT us | se retire | d) | 0, 110,111,11 | | Rosew | | State |
| 5 | 12 | | | | Seam | str | | | | Hospi | | |
| | 17. Fether's Neme (First, Middle, Las. | | | | | | | | | Meiden Sumer | ne) | |
| 2 | Joseph Kinze | - | | | | | | h Br | | | | |
| | 19e. Informent's Name/Reletionship | | | | | , | | | | r, City or Town | | |
| - | Joseph W. Kinz | zer/broti | | Ge of Dispo | | - | Duck | Lane | Dete | 20c. Location | | 2846 |
| | 20e. Method of Disposition 1 XBuriel 2 ☐ Cremation 3 [| Removel from Stete | cen | netery, cret | metory or o | ther ple | | 1 | | | | nster, |
| | 4 □ Donetion 5 □ Other (Speci | | wes | | | | | | 14/20 | OU WE | 2 CHIT | is der, |
| | 21. Signature of Funeral Service Lice | /// | / | D. | ni++ | c F | ss of Fecility | 7 H | ome an | d Cha | pel | |
| | 23a. Pert1. Enter the diseas are on shock, or heert feilure. | T | - |) 4 | 12 W | ash | ingto | n Ro | West | minst | er, | MD 211 |
| | 23a. Pert1. Enter the disease of conshock, or heart feilure. | Aplications that cause y one ceuse on eech I | d the deel ine. | Do not ent | er the mod | de of dylr | ng, such es | cerdiac or | respiretory er | rest, | 1 | Approximete Intervel Betwee Onset end Dee |
| | | | | | | | | ^ | | | 1 | Onset end Dee |
| | Immediate Ceuse (Finel disease or condition resulting in deeth) | · Me | tacle | 2+10 | 15 | rea. | 11 | Car | cer | | 1 | 2 year |
| _ | resouring in occur) | | Due to (or e | es e consec | quence of): | | | | | | | |
| 들 | | b | | | | | | | | | | |
| Examiner | Sequentielly list conditions, if eny, leading to immediate cause. Enter UnderlyIng Ceuse (Disease or injury | | Due to (or e | s e consec | quence of): | | | | | | į | |
| | cause. Enter Underlying Ceuse (Disease or injury that initiated events | c | Due to fee o | | | | | | | | | |
| edicai | resulting in deeth) Lest | | Due to (or e | s e conseq | luence or): | | | | | | | |
| 2 | Design To the | d | | _ | - | | | | | | | |
| cla | Pert li. Other significant conditions | contributing to death t | out not resulti | ing In the u | nderlying c | euse niv | ven in Part I. | | 23b. Did t | obacco use co | ontribute to | the cause of d |
| Physician/ | | oom to dod in | | | g | ,0000 g | | | 10 | / | | bably 4 ☐ Un |
| by | | | | | | | | _ | | | | |
| Completed | | | | | | | | | 24e. Wes | an autopsy med? | av | ere autopsy find aileble prior to |
| De | | | | | | | | | | | co | mpletion of caus death? |
| E | | | | | | | | | 101 | es 2000 | 10 | Yes 2 No |
| d) | 25. Wes cese referred to medical | | | | | | 26. Plece | of Deeth | (Check only o | ne) | | |
| 2 | examiner? 1 ☐ Yes 2 ☑ No | Hospitei: 1 ☐ Inpati | ent 2 El | R/Outpatier | nt 3 D | OA Oth | or: | | | lence 6 🗆 Ot | her (Specif | y) |
| | 27. Menner of Deeth | 28e. Dete of Inju | Jry 2 | 8b. Time o | | 28c. Inju | | | | ow injury occu | | |
| | 1 ☑Neturel 5 ☐ Pending | | y rear/ | Injury | М | | Yes 2 🗆 | No | | | | |
| | 2 Accident investigation | | jury - At hom | e, ferm, st | reet, fector | y, office | | 21 | Sf. Location (S | Street and Num | ber or Run | Il Route Number |
| | 2 Accident investigetic 3 Suicide 6 Could not I | 200. FIGUR OF IT | | | | | | | | .,, | | |
| | 2 Accident investigetion | 28e. Plece of In building, e | с. (Specify) | | | | | | | | | |
| Certification: | 2 Accident 3 Suicide 4 Homicide 29a. Certifier 2 Accident investigetic determined | building, e | of my knowle | | | | | | | | | |
| edical Certification: | 2 Accident 3 Suicide 4 Homicide 29a. Certifier 2 Accident investigetic determined | building, e | of my knowle | | vestigation | , in my c | pinion, dee | | d et the time, | date and place | and due to | the cause(a) |
| edical Certification: | 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only) 2 Medical Exa | hysician: To the best | of my knowle | | vestigation | , in my c | | | d et the time, | | and due to | the cause(a) |
| edical Certification: | 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) Check only one) | hysician: To the best | of my knowle | | vestigation | , in my c | pinion, dee | | d et the time, | date and place. | and due to ed (Month, 4/2 | Dey, Year) |
| edical Certification: | 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) Check only one) | hysician: To the best miner: On the basia of and menner st | of my knowle of examination ated. | n end/or In | vestigation | , in my c | pinion, dee | | d et the time, | date and place. | and due to ed (Month, 4/2 | Dey, Year) |
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DHMH 16 Rev 6/95

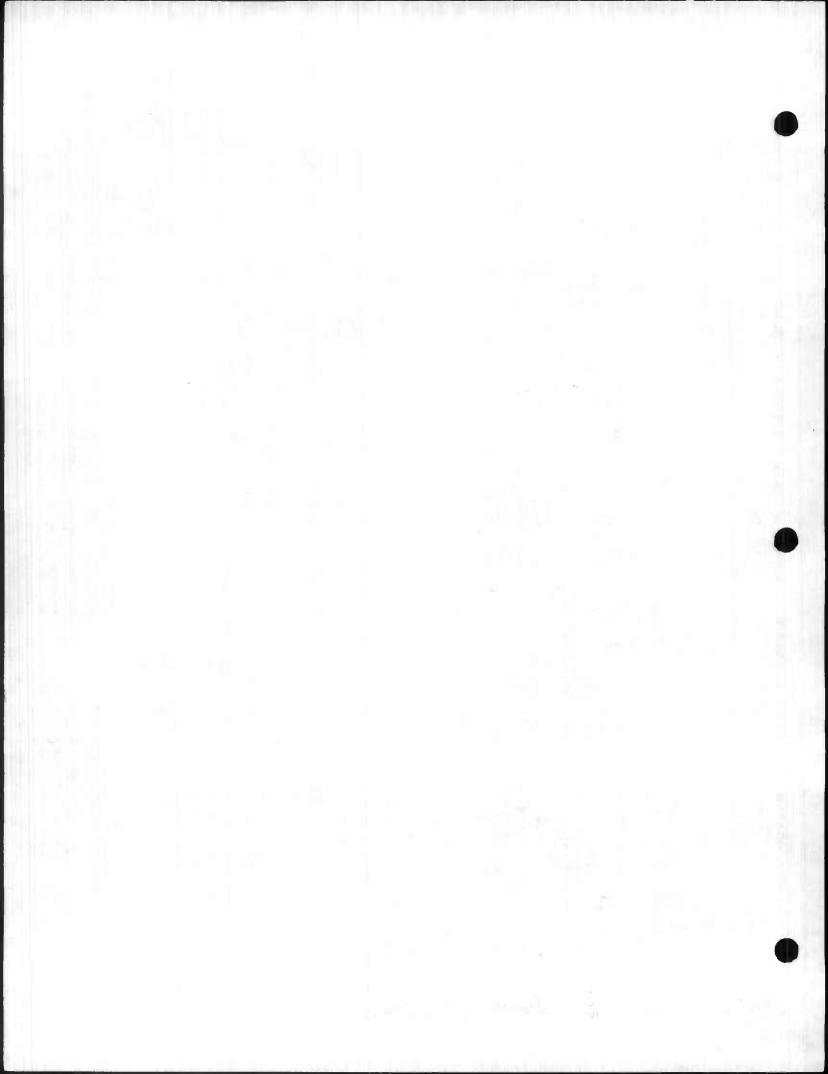
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 15, 2000 Month **Physician** 1610 January Betty Lenora Seese /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner The Memorial Hospital Easton Talbot If Under 24 Hrs. If Under 1 Year Months Days 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Min. Hours 1 M 2 XF Director 022-20-8758 May 29, 1927 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show must be notified at X Yes 2 No Directo Maryland Caroline Denton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ð Berns 23a 21629 804 Camp Road United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ② M☐ No ff Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Bleck, White, etc. than "natural", or live the Medical Examiner 72 hours after 1 Never Married 2 Married 21215-0020 1 Yes 2 No Specify: Specify: Caucasian À 3 DWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Baker 11 HS Grad. Business Person Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 and Mental James Ferdinand Cheezum Ann Margaret Baker Pages 1 and 2 should 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) ä Important: If Item 27 is any injury or other tra-ottos. Terry Hannawald Daughter 25480 Piney Branch Lane, Denton, Maryland 21629 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete B 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/18/00 Denton, Maryland Denton Cemetery 21. Signature of Juneral Se 22. Name and Address of Facility Moore Funeral Home, P.A. 12 South Second Street, Denton, Maryland 21629 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert leiture. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final Pat. disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner Angio sarcomo sician and burial-transit that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): physician s the buria Box 68760, Physician/Medical Due to (or as a consequence of): USB Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part t. Division of Vital Records, P.O. 23b. Did tobacco use contribute to the cause of death? signed by t 1 | Yee 2 do 3 | Probably 4 | Unknown p 24b. Were autopsy lindings evailable prior to completion of cause of death? 24a. Was an autopsy performed? Completed page 2 1 Yes 2 SHO certificate 1 ☐ Yes 2 No or Attending Physician: funeral director. Be 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No Certification: To 1 Depatient 2 ER/Outpatient 3 DOA this 27. Menner of Death 28b. Time of 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury et Work? After 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after deat Funeral Director: 6 ☐ Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. edical 29a. Certifie 2 Medicat Examiner: On the basis of examiner and manner stated. (Check only one) nination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the ceuse(s) Within 2 29c. License number 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) 20053110 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dennis DeShields, M.D., 219 South Washington Street, Easton, Maryland 21601 32. Registrar's Signature State

DHMH 16 Rev 6/95

Registrar

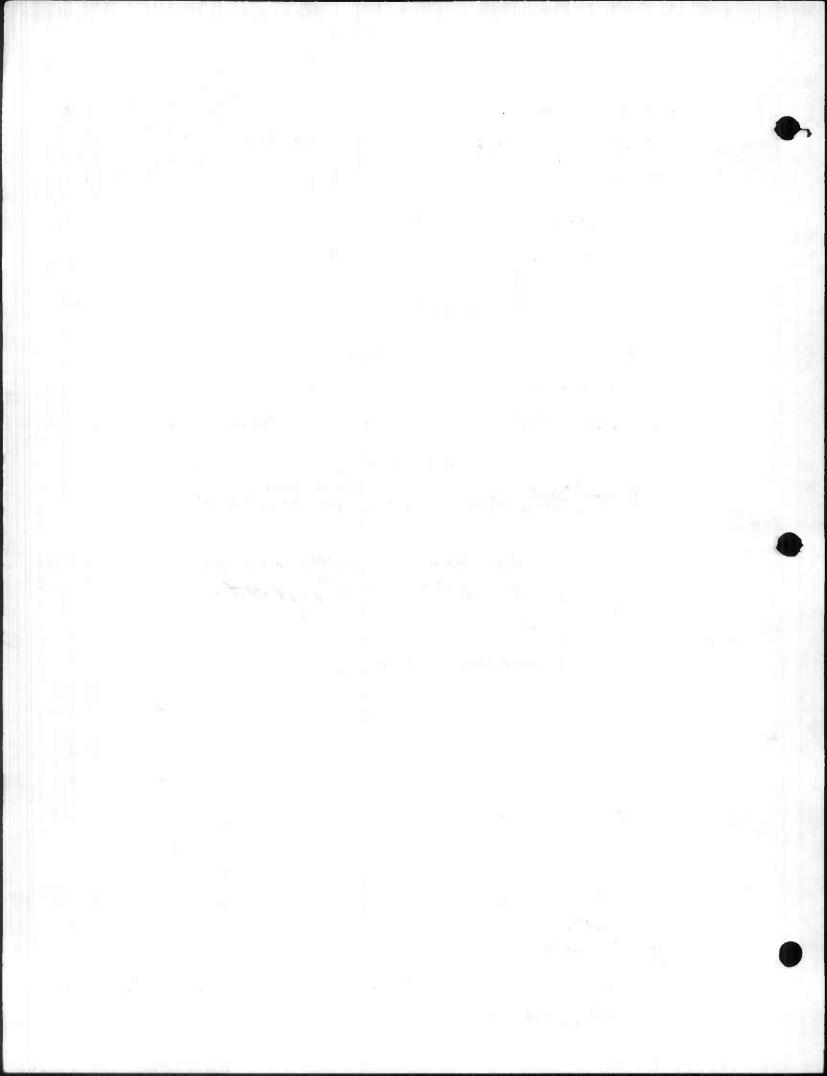
Seese

Betty



State of Maryland / Department of Health and Mental Hygiene 00 00071

| - | | 1. Decedent's Name (First, Middle, L | est) | | | | | 2. Date of Deet | | Verr | 3. Time of Deeth |
|--|--|--|--|--|--|---|--|--|--|--|--|
| Physicia /Medic | _ | Jerry Wayne Sag | er, Sr. | | | | | January | 16, 20 | 000° | 12:03 AM |
| Examin | _ | 4e. Fecility Neme (If not institution, gi | ve street and numbe | or) | | | 4b. City, Town, or L | ocation of Deeth | 4c. County | of Death | |
| | | Washington Adve | ntist Hos | pital | | 1 | Takoma Pa | rk | Montgo | omery | |
| Funeral Director | | 5. Sociel Security Number 6. 202-42-0882 Usuel Residence of Decedent | Sex 7. / 1 → M 2 □ F | Age (In yrs. last birt | Yrs. If Under Months | 1 Year Deys | If Under 24 Hrs. Hours Min. | 8. Dete of Birth (Month, Day, April 1 | 0, 1945 | 9. Birthp Coun Vir | lace (Stete or Foreign try) ginia |
| ahow | | 10e. Stete 10b. County | | 10c. City, Town | or Location | | | | | 11 | 0d. Inside City Limits |
| ms 23a or 28a-f ahow | to | Maryland Charle | S | Wa | aldorf | | | | | | 1 ☐ Yes 2 ☑ No |
| or 28a-f | Director | 10e. Street end Number | | | 10f. Zip | Code | | 1 | 0g. Citizen of \ | Whet Coun | itry? |
| 23a | aiD | 2662 Upbrooke Co | urt | | | 206 | 502 | | USA | | |
| 0 5 | by Funerai | 11. Meritel Status 1 □ Never Married 2 □ Merried 3 □ Widowed 4 ☒ Divorced | 12. Was Deceder Armed Forces 1 [A Yes 2 [If Yes, Give | nt Ever in U,S. s? No s: 1967-71 | | | dispenic Origin? (Spen, Mexican, Puerto Specify: | pecify Yes or No- Rican, etc.) | | ce - Americ ck, White, o | |
| netural', dical Ex | | 15. Decedent's E | ducation | | Decedent's Usua | el Occup | petion | | 16b. Kind of B | | |
| Med Ne | Completed | (Specify only highest gr Elementary/Secondery (0-12) | rade completed) College (1-40 | (54) | (Give kind of wo | rk done se retire | betion during most of world) | ing | | | , |
| giena. | mo. | 12 | Conege (1-40 | Sa | les Pers | on | | | Reta | ail S | ales |
| 1 8 9 | Be (| 17. Fether's Neme (First, Middle, Les | | | | | | e (First, Middle, A | | ne) | |
| | L O | Geroge Ephrim Sa | ger | | | | Agnes H | ope Hoov | er | | |
| 2 0 0 | | 19a. Informent's Neme/Relationship | | | | | end Number or Ru | | - | Stete, Zip | Code) |
| E 4 F | - | Larry A. Sager - | Brotner | | | | oad, Pomf | | | 011 - 7 | |
| if item or othe | | 20e. Method of Disposition 1 □ Buriel 2 🕱 Cremation 3 [| Removel from Stet | comotor | Disposition (Ner y, cremetory or o | ther ple | ce) | Dete | 20c. Location - | - City or To | wn, Stete |
| ant: | | 4 ☐ Donetion 5 ☐ Other (Spec | | | Cremato | rv | 1 | -17-20 0 (| aldorf | , MD | |
| Depertmen Important: any injury once. | | 21. Signature of Funeral Service Lice | Asee / | | 22. Name en | nd Addre | ess of Fecility | | | | |
| Depe Impo any ir | | De Tar | ul | | munitt r | unei | ral Home | | | | |
| | | | Touch MOTI | CA | | 150 | S. Maldon | £ MD 20 | 604 016 | 56 | |
| - 1 | | 23e. Pert1. Enter the disease, or con | ley\ M011 nplications that caus | ed the deeth. Do n | P O Box | 156 de of dyle | 6, Waldor ng, such es cardiec | f, MD 20 or respiretory error | 604-015 est, | 56 | Approximete |
| | | 23e. Pert1. Enter the disease, or cor shock, or heart feilure. List only Immediate Ceuse (Finel | nplications that caus y one ceuse on eech | ed the deeth. Do not line. | P 0 Box | de of dyle | ng, such es cardiec | or respiretory erre | est, | 1 | Onset end Deeth |
| /Medical ixaminer ijel-transit | i Examiner | 23e. Pert1. Enter the disease, or conshock, or heart feilure. List only Immediate Ceuse (Finel disease or condition resulting in deeth) | nplications that caus y one ceuse on eech | POLE POLE POLE POLE POLE POLE POLE POLE | P 0 Box not enter the mod | de of dyle | ng, such es cardiec | or respiretory erre | est, | 1 | Onset end Deeth |
| ruicate be ng physicia as the bu | Aedicai | 23e. Pert1. Enter the disease, or conshock, or heart feilure. List only Immediate Cause (Final disease or condition | e. NEW, b. HA | Due to (or es e o | P 0 Box not enter the mode consequence of): | de of dyle | ng, such es cardiec | or respiretory erre | est, | 1 | Onset end Deeth |
| /Medical bhysician and as the brujel-transit | Aedicai | 23e. Pent. Enter the disease, or conshock, or heart feilure. List only Immediate Ceuse (Finel disease or condition resulting in deeth) Sequentially list conditions, if eny, leading to Immediate cause. Enter Underfying Ceuse (Disease or Injury that initialed events | nplications that caus y one ceuse on eech | Due to (or es e o | P 0 Box not enter the mode consequence of): | de of dyle | ng, such es cardiec | or respiretory erre | est, | 1 | Intervel Between |
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Piease Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Tima of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Daath Month Day Yaar **Physician** hae 1431 JANKa 19 3000 /Medical 4c. County of Death 4a Facility Nama (If not institution, giva street and number, 4b. City, Town, or Location of Death Examiner Lawrel Prince Legiona 1000 George If Undar 1 Yaar 9. Birthplaca (Stata or Foreign Country) If Undar 24 Hrs. 5. Social Security Number 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Yaar) 6 Sax **Funeral** Days 10 M 20 F Months Hours 187-24-3314 66 Jan. 26, 1933 Pennsylvania Director Usual Rasidanca of Dacedant 10a Stata 10c City Town or Location 10d. fnsida City Limits 10b County r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at the Maryla PA York New Freedom 1 Yas 2 No Director 10g. Citizan of What Country? 10e. Street end Number 10f, Zip Coda 17349 108 North Third St. U.S.A. Funeral death 12. Was Dacedant Evar in U.S. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxicen, Puarto Rican, atc.) Armed Forcas? 1 X Yas 2 ☐ No If Yas, Giva Black, White, atc. filed within 72 hours efter 1 Nevar Married 2 Married White altimore, Maryland 21215-0020 1 Yas 2 XNo Specify: Specify: 2 M Yas, Giva Yaar or Datas: Korean 3 Widowed 4 Divorced Completed 16a. Dacedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada complated) Peges 1 end 2 should be filed within nent of Heelth end Mental Hygiene. nt: If Nem 27 Is marked other than Elementery/Secondary (0-12) Collega (1-4or 5+) Federal Government 4 Systems Analyst 18. Mother's Nama (First, Middla, Maldan Surnama) 17 Father's Nama (First Middle Last) Be Elizabeth Orris Angelo Stefano 2 19b. Malling Address (Street and Numbar or Rural Routa Number, City or Town, State, Zip Coda) 19a. informant's Name/Ralationship (Type, Print) Elizabeth C. Wood/Daughter 15016 Northcote Lane, Bowie, MD 20716 other t Date 26 20b. Place of Disposition (Nama of 20c. Location - City or Town, Stata 20a. Method of Disposition Jan. cematary, cramatory or other place 50 1 Burlal 2 Cramation 3 Ramoval from Stata permit. Pege Department o Important: If I any Injury or St. Michael's Cemetery Remus, Michigan 2000 4 ☐ Donation 5 ☐ Othar (Specify) of Funaral Sarvica Licensee 22. Nama and Address of Facility J.J. Hartenstein Mortuary, 24 Second St., New Freedom, PA 17349 isad tha death. Do not antar tha moda of dying, such as cerdiac or respiratory arrest, 23a. Part1. Intar tha disaase, or shock, or haart failura. List Approximate intarval Batween Onset and Death **Physician** CArdio VAscular Disease /Medical Immediata Causa (Final Arterioscherotic disaasa or condition rasulting In daath) Examiner Dua to (or as a consequance of) Examiner Sequantially list conditions, if any, laading to immadiata ceuse. Entar Undarlying Cause (Diseesa or Injury that initiated evants rasulting in daath) Last pue burial-tran Dua to (or as a consequance of): certificate be exec physician Physician/Medical the Dua to (or as a consaguance of): 98 ettending USB for ed by the e Part II. Other significant conditions contributing to deeth but not resulting in the underlying ceuse given in Pert I. 23b. Did tobscco use contribute to the cause of death? signed by t d be detech 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. à 24b. Ware eutopsy findings available prior to completion of ceusa of death? 24a. Was an autopsy performed? Completed peed hes pege 2 1 Yas 1 ☐ Yes 2 ☐ No certificate Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica director, 25. Was cesa rafarrad to medice Be 26. Placa of Death (Check only one) Hospital: 1 Inpatiant Othar: 4 ☐ Nursing Homa 5 ☐ Rasidance 6 ☐ Othar (Specify) 1 Yas 2□ No Lo 2 ER/Outpatient 3 DOA funeral 27. Manner of Deeth 28c. Injury at Work? 28d. Dascribe how injury occurred Certification: 28b. Tima of 1 Natural 5 Panding invastigation 1 Yas 2 No 2 Accidant 3 Suicida 6 Could not be datarmined 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Plece of Injury - At homa, farm, straat, factory, office building, atc. (Spacify) filled in by 4 ☐ Homicida 24 hours 1 Certifying Physician: To tha best of my knowledge, daath occurred et tha time, dete end plece, end dua to tha ceusa(s) and mannar se stated.

2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, daath occurred at tha time, data and place, and dua to tha causa(s) and mannar statad. To the Hospi within 24 hou To the Funer completely fil 29a, Cartifian Medical 29d. Data signed (Month, Day, Year) 29c. Licansa number 29b. Signatura and titla of certifian 2000 30. Name end address of 30. Name end address of 30. impleted cause of deeth (Item 23a) (Type, Print) 31. Data filed (Month, Day, Yaar) 32. Registrar's Signatura State

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Registrar

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| | Physiciar | 001112 | s Neme (First, Midd | | | | | | | 2. Date of De Month | Day | Year | 3. Time of Death |
| ę. | /Medica | JAME | S WILLIA | | | | | | 4b. City, Town, or L | | 09 | 2000 | 0356 |
| | Examine | | eme (If not institution rial Ho: | | East | ton | | | Easton | ocation of Deat | | bot | |
| | Funeral Director | 5. Social Sec | | 6. Sex 12 M 2 □ F | 7. Age (| (In yrs. last birthda Yrs. | Months | 1 | If Under 24 Hrs. Hours Min. | 8. Date of Bir (Month, Da FEB 2 | th | 9. Birthp | lace (State or Foreign try) YORK |
| | , a | Usual Reside | 10b. County | , | 1 | l0c. City, Town or | Location | | | | | 1 | 0d. Inside City Limits |
| | daho | | | EEN ANNE | | STEVENS | | | | | | | 1 ☐ Yes 2 ☑ No |
| | in with the Marylan 23a or 28a-f show | 10e. Street at 402 | | | | | 10f. Zip C | | 1666 | | 10g. Citizen of | What Coun | try? |
| 215-0020 | al', or items | 3 □ Wido | r Married 2 Mei | ried Armed | ecedent Ev Forces? is 2 No Give r Detes: W | | Was Deceder If Yes, specify 1 Pes 2 | | lispanic Origin? (Sp an, Mexican, Puerto Specity: | ecity Yes or No Rican, etc.) | 14. Re Bli Speci | ack, Whita, ify: WH | |
| 2-0 | netural', | | 15. Deceder (Specify only highe | it's Education | nd) | | edent's Usual (| | eation during most of work | ina | 16b. Kind of I | Business/Inc | Justry |
| 7 | tal Hygiene. d other than "naturi | Elementen | y/Secondery (0-12) | College | e (1-4or 5+) | life | DO NOT use | retired | d) | | TEDEDIE | TARO | DATODIEC |
| 0 | Hygie der u | 17. Father's N | . 2 Name (First, Middle, | Last) | | ACCO | UNTANT | | 18. Mother's Nam | | | | RATORIES |
| lan | Mental Mental arked o | JAME | S WILLIAM | | | | | | | E REICH | | | |
| Maryland | 27 is man | 19a. Informa | nt's Neme/Reletion: | | | | | | and Number or Rur OAD, STEV | | | | Code) |
| altimore, | artment of He ortant: If Item Injury or othe | 1 □ Buria 4 □ Done | of Disposition al 2X Cremetion etion 5 ☐ Other (5 | ipecify) | om State | 20b. Plece of Dis cemetery, co CHESAPE CENT | AKE CRE | MA' | | Date 1-13-00 | 20c. Location | | wn, State |
| ga | Depar Impor | 21. Signeture | of Funeral Service | Licensee | | | ELLOWS, | | ss of Facility ELFENBEIN | & NEWN | AM FUNE | ERAL H | OME |
| | hysician /Medical xaminer | Immediate C disease or co resulting in d | ause (Final | r complications the only one cause of | | e deeth. Do not e | nter the mode | of dyin | CK ROAD, ng, such as cardiac no founts | or respiretory e | | .619 | Approximate Interval Between Onset and Death |
| 'n | an end | Sequentially if sny, leedin cause. Enter | list conditions, g to immediate | 5 b. C | | ue to (or es a cons | | di | sure | | | 1 | 12412 |
| BOX 68/6 | nding physic | Cause (Diene | ase or injury events | d | Du | e to (or as a cons | equence of): | | | X | | | |
| Ď | ed for | Pert II. Other | significant conditi | ons contributing to | death but i | not resulting in the | underlying cau | se giv | ren in Part I. | 23b. Did | tobacco uss c | ontribute to | the cause of death? |
| s, r.o | been signed by the ette should be detached for | and | estivi | heart Fo | , line | · pn | mon | 10 | | 10 | Yes 2□ No | 3 Prot | bebly 4 Unknow |
| 9 | las been si | ans | mies | , Anki | plasio | J span | - grit | 2 | | 24a. Wes | an autopsy ormed? | COL | ere autopsy findings allable prior to mpletion of cause death? |
| = F | certificate has b | | | | | | | | | 10 | Yes 2010 | 10 | Yes 2□ No |
| VITAL | this certific | 25. Was case examiner | | 4.0 | Inpatient | 2 ER/Outpati | ent 3 DOA | Oth | 26. Place of Deet her: 4 Nursing Ho | | | | |
| Sion | death. tor: After this the funeral c | | T Death ral 5 Pendii dent invest ide 6 Could | 28a. Da (M getion not be | te of Injury lonth, Day Y | 28b. Time | of 280 | | | 28d. Describe | how injury occu | irred | il Route Number, |
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| 70.00 | within 24 hours | | re end title of pertific | and m | enner stete | | 29c. i | icens | e number | ou at the time, | 29d. Date sign | ed (Month, | CONTRACTOR OF THE PARTY OF THE |
| | | | d address of person | | | | e, Print) | | | MD 0160 | 7 | | |
| | State | 24 Date filed | LD G. ULI (Month, Dey, Year, | | . Registrar's | Signeture | 1 | , | EASTON, | MD 2100 | 11 | | |
| | Registrar | | JAN 1 | 2 2000 | De | nevar | D. M. | 000 | Kel | | | | |

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1 Decedent's Name (First Middle Last) 2. Date of Death Day Month **Physician** CHRISTINE N. SMITH JANUARY 12, 2000 9:17pm /Medical 4b. City, Town, or Location of Deeth 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner 902 Cypresstree Place Capitol Heights Prince Georges If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□ M 2 578-30-8459 Yrs. 73 **Director** Mar. 3,1926 Maryland Usual Residence of Decedent the Maryland 10a. Stete 10b. Count 10c. City, Town or Location 10d. Inside City Limits r than "naturel", or items 23s or 28s-f show the Medical Examiner must be notified at Yes 2□No Directo Md. Prince Georges Capitol Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 902 Cypresstree Place 20743 U.S.A. Funerai death 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes ŽŽNo If Yes, Give Year or Dates: Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. Permit. Peges 1 and 2 should be filed within 72 hours after a Copartment of Health and Mental Hygiena. Important: if Item 27 is marked other than "naturel", or its eny injury or other treumatic event, the Magical Examina Pace. 1 □ Never Married 2 □ Married Specify: Black Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: þ XX Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 2years Administrative Asst. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Vernell Livingston Eugene Walkinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Charlene C. Boyd/Daughter 200 K St., N.W. #609 Wash. D.C. 20001

20b. Place of Disposition (Name of cametery, cremetory or other place)

20c. Location - City or Town, Stete 20a. Method of Disposition Burlel 2 Cremetion 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/19/00 Landover, Md. Harmony Memorial Pk 22. Name and Address of Facility Johnson & Jenkins Inc. 21. Signature of Funeral Service Licenses 716 Kennedy St., N.W. Wash. D.C. 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death **Physician** /Medicai Immediate Cause (Final disease or condition resulting In deeth) 1week ACUTE MYELOID LEUKEMIA Examiner Due to (or as a consequence ot): Examiner certificate be axecuted sician and burial-trans Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. physician Physician/Medical the Due to (or as a consequence of) USB as ! 23b. Did tobacco use contribute to the cause of death? Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yee 2 No 3 Probably 4 Unknown signed l Division of Vital Records, by 8 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Was en autopsy periormed? Completed page 2 s certificate has 1 ☐ Yes XX No 1 Yes 200No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 TResidence 6 Other (Specify) To 1 Yes 2\No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral 28b. Time of tnjury 28d. Describe how Injury occurred 27 Manner of Death 28a. Date of Injury (Month, Dey Year) Certification: 28c. Injury at Work? or Attending 1X Watural 5 Pending 1 ☐ Yes 2 ☐ No 24 hours after death. investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital edicai Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated. 29a. Certifier completaly (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, end due to the cause(s) and manner stated. To the Y within 2 29d. Date signed (Month, Dev. Year) 29b. Signature and title of certifier 29c. License number D46704 January 13,2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mutombo Kankende ,kaiser Permanente, Largo, Md.

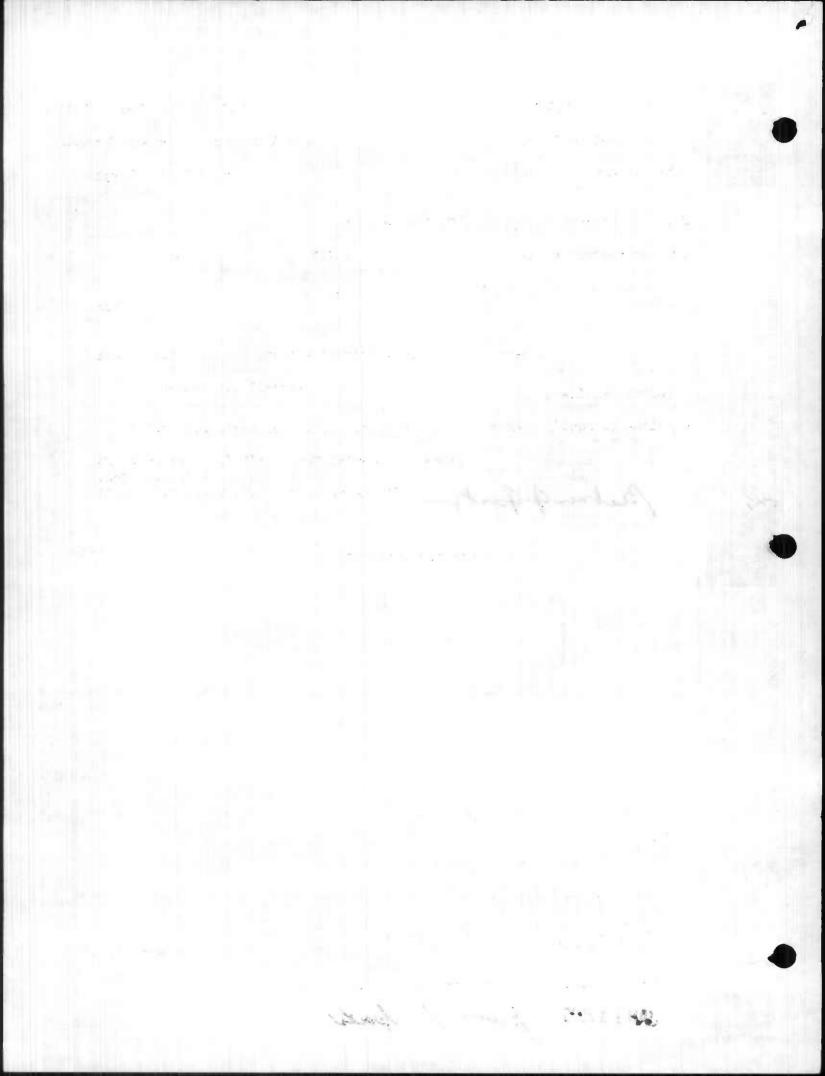
32. Registrar's Signature

DHMH 16 Rev 6/95

Registrar

31. Date filed (Month, Day, Yeer)

JAN 1 4 2000



State of Maryland / Department of Health and Mental Hygiene

| (Specify only higher (Specify only higher (12) 12th 12th 12th 12th 12th 12th 12th 12th | Gary ion, give street and not land Hosp: 1 | 7. Age (fn yrs 51 10c. C C C C C C C C C C C C C C C C C C C | Vrs. Vrs. City, Town or Clintol U.S. 1 16a. Dec (G) Senic | if Under 1 Months I Location 10f. Zip C 2073 3. Wes Deceder If Yes, specify 1 Yes, specify 1 Yes, specify ince kind of work ince NOT use Or Prince eiling Address (3 30 Armo) sposition (Name crematory or other ill Ceme 22. Name and 6633 O | Clintor Year If Under 24 Days Hours Code 35 Int of Hispanic Origin y Cuban, Mexican, F S No Specify: Occupation done during most or retired) 18. Mother's Ca: Street and Number or r Drive C. of er piece) etery Jan Address of Facility Id Alexan | Repetit Yes or Nuerto Rican, etc.) Working rolls Mgr Neme (First, Middle therine r Rural Route Num Linton, M Date 14,2000 Lee Fune Rican Ferr | 10g. Citizen of Nu. S. 10g. Citizen of Nu. S. 14. Race Blace Specify 16b. Kind of Be American Lanhar Lanhar Suitla Tal Home y Road Co. | 9. Birthplace (State or Foreign Washington DC Washington DC 10d. Inside City Limit 1 |
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| Facility Name (If not institution Southern Mary). Southern Mary. Social Security Number 79-64-7605 uel Residence of Decedent a. Stete 10b. County laryland Prince e. Street and Number 6330 Armor Dr. Marital Status 1 Never Married 2 Mer 3 Widowed 4 Divorced (Specify only higher Elementery/Secondery (0-12) 12th Father's Neme (First, Middle, Ralph Norris e. Informent's Neme/Reletion Linda M. Sma e. Method of Disposition 1 Mauriel 2 Cremation 4 Donetion 5 Other (S. Signeture of Funerel Service shock, or heert failure. List mediate Ceuse (Final seese or condition sulting in death) | ton, give street and not land Hosp: 6. Sex | 7. Age (fn yrs 51 10c. C C C C C C C C C C C C C C C C C C C | s. last birthd. Yrs City, Town or Clintol U,S. 1 16a. De (G) (H) Seni. 19b. M. 63 Place of Diccemetery, cedar H | if Under 1 Months I Location 10f. Zip C 2073 3. Wes Deceder If Yes, specify 1 Yes, specify 1 Yes, specify ince kind of work ince NOT use Or Prince eiling Address (3 30 Armo) sposition (Name crematory or other ill Ceme 22. Name and 6633 O | Clintor Year If Under 24 Days Hours Code 35 Int of Hispanic Origin y Cuban, Mexican, F S No Specify: Occupation done during most or retired) 18. Mother's Ca: Street and Number or r Drive C. of er piece) etery Jan Address of Facility Id Alexan | Janua: or Location of Deal or Location of Deal line. 8. Dete of B. Month. E. Sept. R (Specify Yes or Numberto Rican, etc.) working colls Mgr Neme (First, Middle therine r Rural Route Num Linton, M Dete 14,2000 Lee Fune Rica Ferr | 10g. Citizen of VU.S 10g. Citizen of VU.S 14. Rac Blac Specify 16b. Kind of Br. Ameri 2. Meiden Suman Lanha ber, City or Town, aryland 20c. Location—Suitla ral Home y Road C | of Death Ce George's 9. Birthplace (State or Fore) Washington DC 10d. Inside City Limit 1 Yes 2 CN What Country? A. e - American Indian, k, White, etc. White usiness/Industry can Management Systems M State, Zip Code) 20735 City or Town, State and, Maryland , Inc. linton, MD207 Approximata Interval Between |
| Southern Mary: Social Security Number 79-64-7605 uel Residence of Decedent a. Stete 10b. County laryland Prince e. Street and Number 6330 Armor Dr. Marital Status 1 Never Married 2 Mer 3 Widowed 4 Divorced (Specify only higher Elementery/Secondery (0-12) 12th Father's Neme (First, Middle, Ralph Norris e. Informent's Neme/Reletion Linda M. Sma e. Method of Disposition 1 Mauriel 2 Cremation 1 Mauriel 2 Cremation 1 Mauriel 2 Cremation 1 Donetion 5 Other (S. Signeture of Funerel Service b. Signeture of Funerel Service shock, or heert failure. List mediate Ceuse (Final seese or condition sulting in death) | cland Hosp: 6. Sex 12 M 2 F 13 M 2 F 15 F 16 George 12. Was Decay of the seried o | 7. Age (fn yrs 51 10c. C C C C C C C C C C C C C C C C C C C | Vrs. Vrs. City, Town or Clintol U.S. 1 16a. Dec (G) Senic | Months T Location 10f. Zip C 2073 3. Wes Decedent If Yes, specifity exing of work or Prince eiling Address (3 30 Armo) sposition (Name crematory or other ill Ceme 22. Name and 6633 0 | Clintor Year If Under 24 Days Hours Code 35 Int of Hispanic Origin y Cuban, Mexican, F S No Specify: Occupation done during most or retired) 18. Mother's Ca: Street and Number or r Drive C. of er piece) etery Jan Address of Facility Id Alexan | Working Neme (First, Middleherine FAUTE ROUTE Num Linton, M Date 14,2000 Lee Fune Aria Ferr | Prince 10g. Citizen of V U.S. 14. Race Blace Specify 16b. Kind of Be Ameri 2. Meiden Suman Lanha ber, City or Town, aryland 20c. Location— Suitla ral Home y Road C | 9. Birthplace (State or Foreign Washington DC 10d. Inside City Limit 1 |
| Social Security Number 79-64-7605 uel Residence of Decedent a. Stete 10b. County laryland Prince e. Street and Number 6330 Armor Dr. Marital Status 1 Never Married 2 Mer 3 Widowed 4 Divorced (Specify only highe Elementery/Secondery (0-12) 12th Father's Neme (First, Middle, Ralph Norris le. Informent's Neme/Reletion Linda M. Sma e. Method of Disposition 1 Marital Status 1 Signeture of Funerel Service 3 Pert 1. Enter the disease, of shock, or heart failure. List seese or condition sulting in death) | 6. Sex 12 M 2 F ty the George I Tive 12. Was Deferried I 1 Yes If Yes, Ged Yeer or ent's Education lest grade completed 2 College 2 Small Jr enship (Type, Print) all (Wife) 13 Removel from (Specify) Licensee | 7. Age (In yrs 51 10c. C C C C C C C C C C C C C C C C C C C | Vrs. Vrs. City, Town or Clintol U.S. 1 16a. Dec (G) Senic | Months T Location 10f. Zip C 2073 3. Wes Decedent If Yes, specifity exing of work or Prince eiling Address (3 30 Armo) sposition (Name crematory or other ill Ceme 22. Name and 6633 0 | Year II Under 24 Days Hours Code 35 Int of Hispanic Origin y Cuban, Mexican, F X No Specify: Occupation done during most or retired) 18. Mother's Ca: Street and Number or r Drive C. of er piece) etery Jan Address of Facility Id Alexan | Repetit Yes or Nuerto Rican, etc.) Working rolls Mgr Neme (First, Middle therine r Rural Route Num Linton, M Date 14,2000 Lee Fune Rican Ferr | 10g. Citizen of V U.S 10g. Citizen of V U.S 14. Race Blace Specify 16b. Kind of Brown American Lanhar Lanhar 20c. Location - Suitla ral Home y Road Co | 9. Birthplace (State or Forei Washington DC |
| uel Residence of Decedent a. Stete 10b. County laryland Prince e. Street and Number 6330 Armor Dr. Marital Status 1 Never Married 2 Mer 3 Widowed 4 Divorced (Specify only highe Elementery/Secondery (0-12) 12th Father's Neme (First, Middle, Ralph Norris le. Informent's Neme/Reletion Linda M. Sma e. Method of Disposition 1 Marital 2 Cremation 4 Donetion 5 Other (8 Signeture of Funeral Service bases or condition sulting in death) | ty ce George Tive 12. Was Defermed Figure 12. Was Defermed 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 | 51 S 10c. C C C C C C C C C C C C C C C | Vrs. Vrs. City, Town or Clintol U.S. 1 16a. Dec (G) Senic | Months T Location 10f. Zip C 2073 3. Wes Decedent If Yes, specifity exing of work or Prince eiling Address (3 30 Armo) sposition (Name crematory or other ill Ceme 22. Name and 6633 0 | Days Hours Code 35 Int of Hispanic Origin y Cuban, Mexican, F No Specify: Occupation done during most or retired) 18. Mother's Ca: Street and Number or r Drive C. of er piece) etery Jan Address of Facility 1d Alexan | Working Tolls Mgr Neme (First, Middle therine Formal Route Num Linton, M Date 14,2000 Lee Fune Sept. | 10g. Citizen of VU.S 14. Rac Blac Specify 16b. Kind of Be Ameri 9. Meiden Suman Lanha ber, City or Town, aryland 20c. Location - Suitla ral Home y Road C | Washington DC 10d. Inside City Limit 1 Yes 2 CAN What Country? A. e - American Indian, k, White, etc. White usiness/Industry can Management se) Systems M State, Zip Code) 20735 City or Town, State nd, Maryland , Inc. linton, MD207: Approximata Interval Between |
| a. Stete 10b. County Prince Iaryland Prince e. Street and Number 6330 Armor Dr. Marital Status 1 Never Married 2 Mer 3 Widowed 4 Divorces 15. Deceder (Specify only highe Elementery/Secondery (0-12) 12th Father's Neme (First, Middle, Ralph Norris e. Informent's Neme/Reletion Linda M. Sma e. Method of Disposition 1 Muriel 2 Cremation 4 Donetion 5 Other (3 Signeture of Funerel Service 3a. Pent1. Enter the disease, o shock, or heart failure. List mediate Cause (Final seese or condition sulting in death) | rive 12. Was Defamed Famed Fa | s C cedent Ever in the Forces? 2 (2 (2) No dive Detes: (1) (1-4or 5+) Cell caused the decearch line. | U.S. 1 16a. De (Gilling) Senice 19b. Mr. 63 Place of Discometery, cedar H | 10f. Zip C 2073 3. Wes Deceder If Yes, specifityes, spec | nt of Hispanic Origins of Cuban, Mexican, F. No. Specify: Occupation done during most of retired) 18. Mother's Ca: Street and Number of Prive C. of er plece) etery Jan Address of Facility Id. Alexani | working rolls Mgr Neme (First, Middle therine r Bural Boute Num Linton, M Date 114,2000 Lee Fune dria Ferr | U.S Specify 16b. Kind of Br. Ameri Ameri Ameri Anha Lanha 20c. Location Suitla ral Home y Road Co | Mhat Country? A. e - American Indian, k, White, etc. White usiness/Industry can Management se) Systems m State, Zip Code) 20735 City or Town, State nd, Maryland , Inc. linton, MD207: Approximata Interval Between |
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| Ja. Pert1. Enter the disease, o shock, or heert failure. List imediate Ceuse (Final seese or condition sulting in death) aguartially list conditions, may leading to immediate use. Enter Underlying use (Disease or injury | 2 th | 020 | eth. Do not | 6633 O | ld Alexan | dria Ferr | y Road C | linton, MD207 |
| mediete Ceuse (Final seese or condition sulting in death) squentially list conditions, any, leading to immediate use. Enter Underlying use (Disease or injury | or complications that st only one cause on | 020 | eth. Do not | | | | | Approximata Interval Between |
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| st initiated events sulting in death) Last | $\{ -$ | Type to (| (or as e con | sequence of): sequence of): | re h | das | diseas | i year |
| | | | | | | | | |
| II. Other atgnificant condition | diona contributing to | deeth but not re | wesulting in the | e underlying cau | ise given in Part I. | | | ntribute to the cause of deat 3 Probably 4 Unkno |
| | | | | | | | s an autopsy formed? | 24b. Were autopsy findings available prior to completion of cause of death? |
| | | | | | | A | Yes 2 No | or death? |
| Was case referred to medica | al | | | | 26 Place of | Death (Check only | | 10 765 225-00 |
| examiner? | Hospitel: | Inpatient &D | X ER/Outpa | tient 3 DOA | Other | | | er (Specify) |
| | ing (Moi | e of Injury | 28b. Time | | | 28d. Describe | how injury occur | red |
| 3 Suicide 6 Could determ | mirrord Spe. P180 | | | street, fectory, o | office | 281. Location City or T | (Street and Numb own, State) | er or Rural Route Number, |
| | ing Physician: To the | | | eth occurred et | | | | |
| | I Examiner: On the I | basis of examin | | | n my opinion, death | | | and the same of th |
| : Signature and title of certific | Examiner: On the I | basis of examin | | r investigetion, in | License number | | 29d. Date/signe | d _y (Month, Day, Year) |
| Signature and title of certific | Examiner: On the I | basis of examin | | r investigetion, in | | 20 | 29kl. Date[signe | 2000 |
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| | 1 Yes 2 No Manner of Death Statural 5 Pend 2 Accident inves 3 Suicide 6 Coult 4 Homicide | Manner of Death Manner of Death Shatural Accident Suicide G Could not be ZBa. Place Manner of Death Sharing 1 Inpatient Manner of Death Sharing 1 Inpatient Manner of Death Sharing 28a. Date of Injury (Month, Dey Year) 28a. Date of Injury (Month, Dey Year) 28a. Place of Injury - At building, etc. (Special Countries of Coun | Hospitel: 1 Inpatient MER/Outpa | Hospitel: 1 Inpatient AMER/Outpatient 3 DOA | Ves 2 No | Hospitel: 1 Inpatient MATER/Outpatient 3 DOA Other: 4 Nursing Home 5 Res | Hospitel: 1 Inpatient ACER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Oth Manner of Death Manner of |

DHMH 16 Rev 6/95

SAME SOURCE WAS

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death **Physician** January 12, 2000 12:55AM Carl Melvin Suit /Medical 4b. City, Town, or Location of Death 4e Facility Neme (If not institution, give street end number) 4c. County of Death Examiner Prince George's Southern Maryland Hospital Clinton If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) Jan. 1, 1904 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 F Days Months Hours Maryland Yrs. 96 Director 217-36-6589 Usual Residence of Decedent the Mandand 10b. County 10c. City, Town or Location 10d. toside City Limits 1 Yes 2 No Directo Upper Marlboro Maryland Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? THE 23s OF 20772 U.S.A. 7300 Croom Station Road Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 ☐ Yes 2 No If Yes, Give Yeer or Detes: filed within 72 hours after 1 Never Merried 2 Merried specify: White 21215-0020 ò 1 Yes 2 No Specify: Be Completed by 3 ₩idowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygien Important: If item 27 is marked other th any fulury or other traumatic avent, tra pages. 12th N/A Farmer Farming Baltimore, Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Mary E. Harvey Joseph Jackson Suit 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Neme/Reletionship (Type, Print) Anthony Wells (Foster Son) P.O. Box 600 Upper Marlboro, Maryland 20773 20b. Place of Disposition (Name of cemetery, cremetory or other place)

Jan. 15 Pate 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Removel from Stete 2000 Clinton, Maryland Resurrection Cemetery 4 Donation 5 Other (Specify) Lee Funeral Home, Inc. 21. Signeture of Funeral Service License 22. Name end Address of Facility 6633 Old Alexandria Ferry Road Clinton, MD 20735 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Final Puermania 2 days disease or condition resulting in deeth) Examiner Examiner tailure days cute reucel The law requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest and Vascular Box 68760, pheval Physician/Medical the Due to (or es a consequen USB AS Covouav cons Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown dementia Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? po fly voidism certificata has 1 Yes 20 No Venal insuficiency 29 No Chronic 1 ☐ Yes 25. Was case referred to medical examiner? or Attending Physician: funeral director. 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No this Menner of Death 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Affer 5 Pending investigation death. 1 Yes 2 No 2 Accident 24 hours after deat Funeral Director: 6 Could not be determined To the Hospital or Atterwithin 24 hours after der To the Funeral Director completely filled in by th 3 Suicide 281. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the besta of examinetion and/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) and menner steted. 29d. Date signed (Month, Day, Year)

January 12/ 29b. Signeture and title of certifie 29c. License number D42049 pala my 30. Neme and address of person who completed cause of deeth (item 23a) (Type, Print)

State Registrar 6.

upper Maulbors. Md 20772 CHAMPALOUX MD_ Registrer's Signeture

DHMH 16 Ray 6/95

JAN ! 2882 Janes A September 1

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Dete of Deeth 1. Decedent's Neme (First, Middle, Last) **Physician** Arthur Gregory Stroinski January 10, 2000 11:00 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Waldorf, Maryland Charles Co. 2000 Wendy Ct. Months Days Hours Min. 8. Dete of Birth (Month, Day, Year) Feb. 23,1951 6. Sex 1 M 2 □ F 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplaca (Stete or Foreign Country) Funeral Months 48 Yrs. **Director** 470-58-7359 Usuet Residence of Decedent 10a. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 1 No Maryland Directo Charles Waldorf 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 2000 Wendy Ct. 20601 U.S.A. Funeral 12. Wes Decedent Ever In U.S. Amed Forces? 123 Ases 2 □ No 1971 — If Yes, Give Year or Detes: 1994 Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indien. 11. Marital Stetus Black, White, etc. 1 Never Married 2 Merried 1 Yes 2 No Specify: White à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

16b. 1

16b. 1

16c. 1 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Eiementery/Secondery (0-12) Service Packaging Mail Self-employed permit. Pages 1 end 2 should be filled v. Department of Health end Mental Hygien Important: If Item 27 Is marked other the any Injury or other traumatic avent, Italia page. 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Fether's Name (First, Middle, Last) Be Julius Arthur Stroinski Jacqueline Sleeth 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Retetlonship (Type, Print) Kum O. Stroinski (Wife) 2000 Wendy Ct. Waldorf, Maryland 20601 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 Buriel 2 Cremation 3 Removel from State Clinton, Maryland 4 Donetion 5 Other (Specify) Lee Crematory January 14, 2000 Clinton, Maryla 22. Neme end Address of Fecility Lee Funeral Home, Inc. 21. Signeture of Funeral Service L 6633 Old Alexandria Ferry Road Clinton, MD20735 M01095 plication. The caused the deeth. Do not enter the mode of dylng, such as cardiac or respiratory arrest, one cause on each line. 23a. Part1. Enter the disease shock, or heert feilure. I Approximete Intervat Between Onset and Death **Physician** Coronary Aftery 1 /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or es e consequence of): Examiner Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initieted events resulting in deeth) Lest Physician/Medical Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were eutopsy findings available prior to completion of cause of deeth? 24e. Wes an autopsy Completed 1□ Yes 2 No 1 Yes 2 No 25. Wes case referred to medical exeminer? Be 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 □Other (Specify) 1 Yes 2 1 Inpatient 2 ER/Outpetient 3 DOA 28e. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 27. Menner of Death 28b. Time of 28c. injury et Work? Certification: 1 Neturel 2 Accident 5 Pending investigation 1 Yes 2 No 6 Could not be determined

P.O. Box 68760.

physician and s the buriel-trans certificate be axecu 88 980 signed l Division of Vital Records, certificate has birector, page 2 s this funeral Aftar or Attanding r death. 6 Direc 24 hours

the Maryland

death

filed within 72 hours after

altimore, Maryland 21215-0020

r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

Medical To the 7 To the 9 complet

Registrar

use of deeth (Item 23a) (Type, Print)

3 Suicide

29a. Certifier

29b. Signat

4 Homicide

Dete filed (Month, Day, Year) JAN 1 3 2000 32. Registrer's Signature

Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

PERWIFTER RS, AAFB MY

Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examinar: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the

Ind. On the besis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the causa(s) end menner stated.

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29c. License number

PA

28f. Location (Street end Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Dev. Year)

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State of Maryland / Department of Health and Mental Hygiene

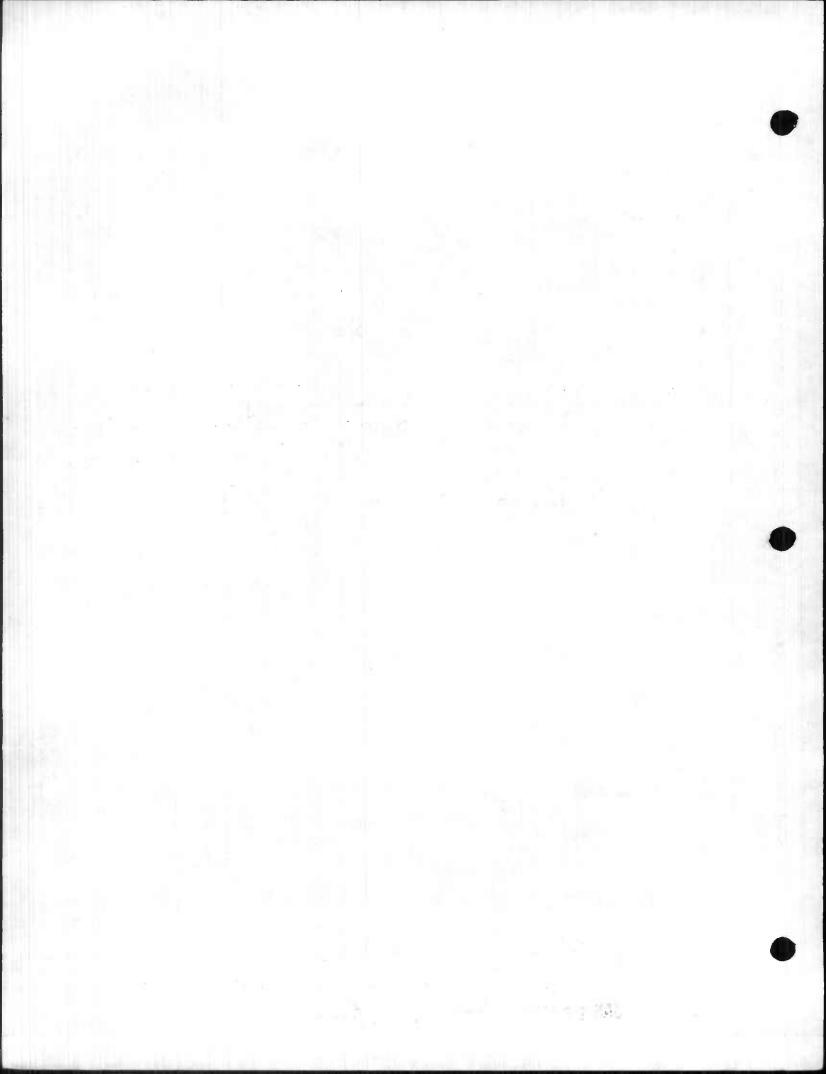
Certificate of Death 1. Decedent'e Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month **Physician** January 16 2000 10:34 AM DAWN MARIE STIMMELL /Medical 4b. City. Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Clinton r | If Under 24 Hrs. Southern Maryland Hospital Center Prince George's If Under 1 Year Birthplece (State or Foreign Country) 8. Dete of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Hours Director 36 FEB 21 1963 208 56 6821 Pennsylvania Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or itema 23s or 28s-f show the Medical Examiner must be notified at 1 Yes 2 No Director Maryland Charles Waldorf 95 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3804 Owen Court 20602 USA Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, 11. Merital Stetus 12. Wes Decedent Ever in U,S. Armed Forces? Bleck, Whita, etc. filed within 72 hours after thygiene. 1 ☐ Yes 2 No 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☒ No Specify. specify: White à 3 ☐ Widowed 4 ☐ Divorced Yeer or Detes: Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Disabled None 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) Be To Kenneth L. Stimmell Sr Hazel M. Williams Stimmell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) Irvin E. Williams (Uncle) 5475 Port Tobacco Road Indian Head, MD 20640 20b. Plece of Disposition (Name of cametery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Slate Burial 2 Cremetion 3 Removel from Stete 1-19-00 Lafayette Mem. Park Fayette County, PA mont Funeral Service Licenses 22. Name end Address of Fecility Eberwein Funeral Services M00173 4433 White Pls La White Pls., MD 20695 leus 23a. Part Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feilure. List only one cause on each line. Approximate Intervel Between Onset and Deeth **Physician** /Medical Immediete Cause (Finel res disease or condition resulting in deeth) Examine Examine The law requires that the death certificate be executed physician and is the burial-trans Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Due to (or as e consequence of) Box 68760. Physician/Medical Due to (or es e consequence of): 88 P.0. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed has page 2 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vitai Physician: 8 25. Wes case referred to medical exeminer? 26. Piace of Deeth (Check only one) Hospitef: 10 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1X inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? Certification: 28d. Describe how injury occurred After t To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After 5 Pending Investigation 1 Neturel
2 Accident after death.

I Director: Aft din by the fur 1 Yes 2 No 6 ☐ Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homlcide edical Letter ng Physician/ To the best of my knowledge, deeth occurred at the time, dete end place, and due to the cause(s) and manner as stated.

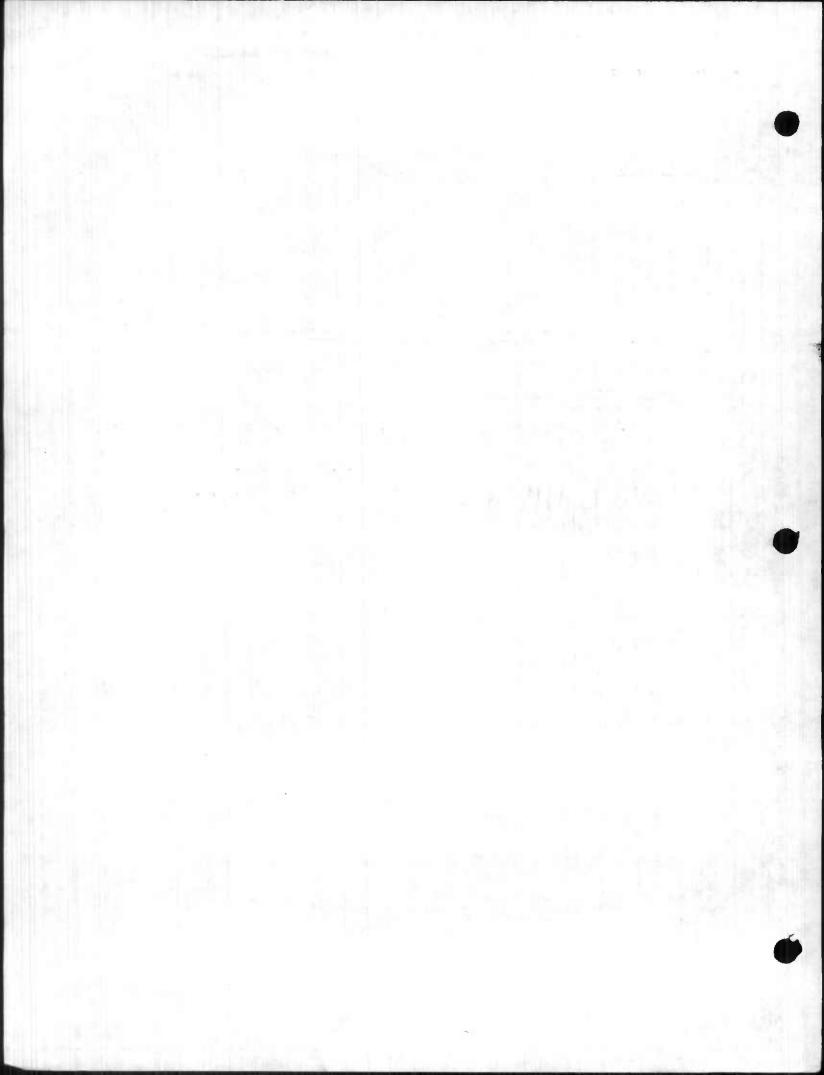
Letter ng Physician/ To the best of my knowledge, deeth occurred at the time, dete end place, and due to the cause(s) and cause(s) and menner stated. 29e. Certifier 29d. Dete signed (Month, Day, Year) 29b. Signature and little of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11345 Pembrooke Square #104 Waldorf, MD 20603 MD., Daniel M. Howell, JAN 1 8 2000 32. Registrar's Signeture State Registrar

DHMH 16 Ray 6/95



| | em#5 perFH 1. Decedent's Nam | ougn Der me G781 3/8/200 ne (First, Middle, Last) | O EW | | Centilica | ate of t | Death | 2. Data of | Death | | | 2382 3. Time of Death |
|--|--|--|--|--|--|---------------------------------------|--|---|--|---|---|--|
| hysician | John | Malcolm | Scarbor | rough | | | | Janua: | | Day 2 | Year 000 | 11:51 A. |
| /Medical Examiner | 4a Facility Nama (| If not institution, giva | street and number) | | | 4 | b. City, Town, | or Location of De | ath | 4c. County | of Death | |
| | | lston Gene | | | Milan | das 1 Vans | Falls | | 21.11 | Н | arfor | |
| ector | 5. Social Security 1 231-72-24 Usual Residence of | 640- | 7. Age | e (In yrs. la 45 | Yrs. If Uni | der 1 Yaar ns Days | | | Day, Ye | 954 | 9. Birthpl Count Mary | laca (Stata or Foraig try) "Land |
| | 10a. Stata | 10b. County | | 10c. City, | , Town or Location | | 12.77 | | П | | 10 | 0d. Inside City Limits |
| 2 - | Maryland 10e. Street and Nu | Harford | | Bel | | 7:- Codo | | | 100 | Citizen of h | Africa Course | |
| | 114 Seevi | | | | | Zip Code | | | | Citizen of V USA | WHAT COURT | try r |
| 2 | 11. Marital Status | | 12. Was Decedent E | Ever in U,S | | | ispanic Origin? | (Specify Yes or arto Rican, etc.) | | 14. Rac | e - Amarica | |
| 2 | 1 ☑ Nevar Marr 3 ☐ Widowed | ried 2 Married 4 Divorced | Armed Forces? 1 ☐ Yas 2 ☒ N If Yes, Give Year or Datas: | No | | pecify Cubs | Specify: | arto Hican, etc.) | | Specify | ok, Whita, e | |
| ered | (Spe | 15. Decedant's Edu | | | 16a. Decedent's U (Give kind of | sual Occup work dona | ation during most of | working | 166 | . Kind of B | usinass/Ind | Justry |
| Completed | Elemantary/Second | College (1-4or 5 | i+) | | | " - Disab | | | | | | |
| | | (First, Middle, Last) | | | onemp. | Loyeu | | Nama (First, Mid | dle, Mai | dan Suman | ne) | Total Color |
| To Be | Merril | Flaa So | arborough | | | | Esthe | r Ire | 16 | Mahai | n | |
| | | ame/Relationship (Ty | | | 19b. Mailing Addr | ass (Street | | | | | - | Code) |
| | | . Scarboro | ugh-Fathe | | 4328 Cond | | Road, | | | | | |
| 1 | 20a. Method of Disposition 20b. Placa of Disposition (Name of cemetery, crematory or other placa) 20c. Location - City or Churchvil. | | | | | | | | | | | |
| - | 4 Donation 5 Other (Specify) Smith Chapel U.M. Church Jan. 24, 2000 | | | | | | | | | | | |
| | 1 TO | | | | | | | | | | | |
| | A 0 10 11 | I V NY | VI | | McCor | mac Th | meral | Home, P. | Α. | | | |
| | A 0 10 11 | I V NY | VI | the death. | McCor | mac Th | meral | Home, P. | A. | on, M | aryla | nd 21009 |
| | A 0 10 11 | aase, or compliance. List only or | VI | the death. | McCor | mac Th | meral | Home, P. Dad, Abadiac or respirator | A. ngde y arrest, | on, M | aryla | nd 21009 Approximate Interval Between Onset and Death |
| | 23a. Pert1. Enter shock or hee | n aase, or compli nure. List only or | cations that caused ne cause on each lin | | McCor 1317 Do not enter the m | nas Fi Cokes node of dyin | meral | Home, P. | A. Ingdey arrest, | on, M | aryla | nd 21009 Approximate Interval Between Onset and Death |
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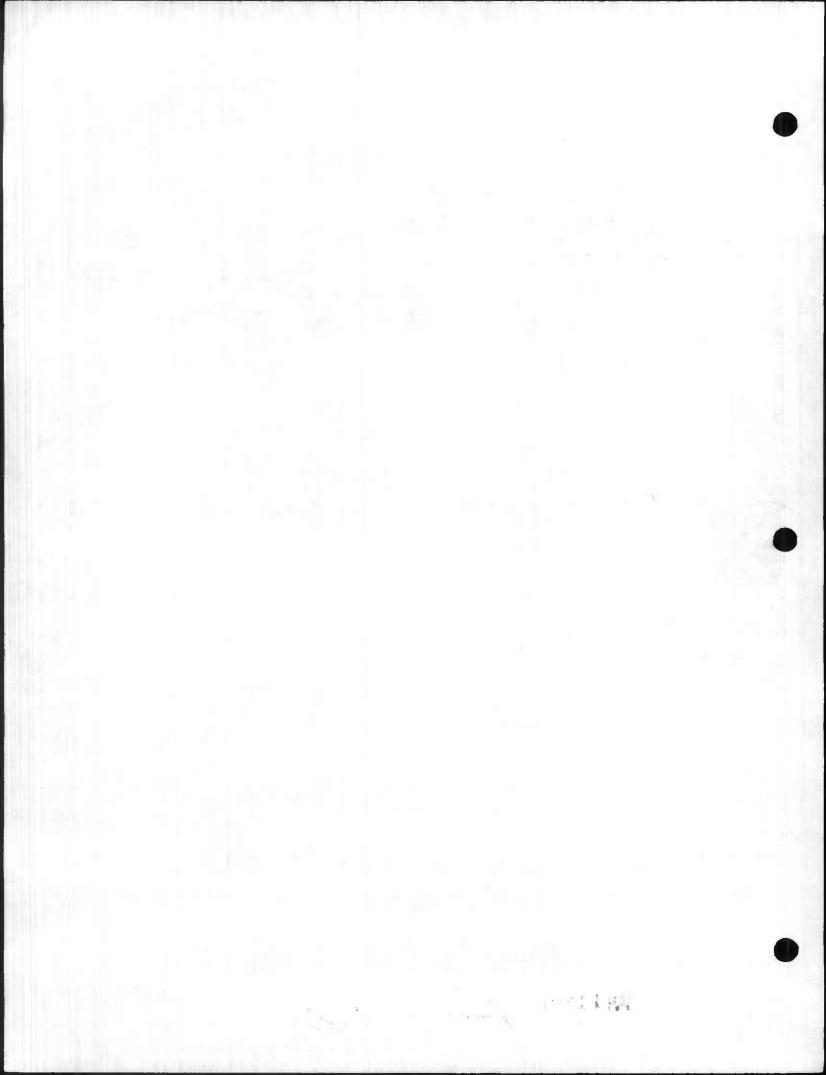
DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

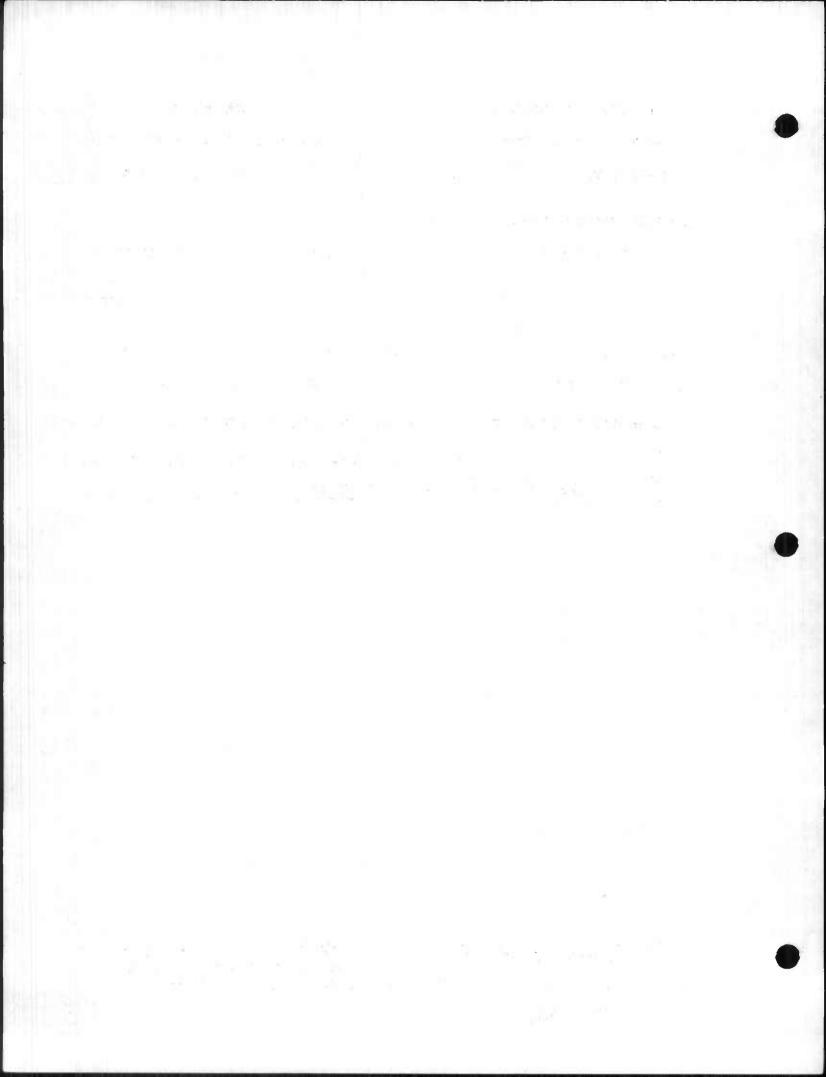
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| nysician | | | | | | Month | Day | Year | | | |
| Medical | , | tewart | | | 4b. City, Town, or | January | - | | 0 p.m. | | |
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| | Magnolia Gardens N 5. Sociel Security Number 6. Sex | <u> </u> | rrs. lest birthday) | If Under 1 Year | Lanham If Under 24 Hrs | 8. Date of Birth | Prince | e George | | | |
| neral ector | 578-22-0129 1X | IM 2□ F 75 | Yrs. | Months Days | | | , 1924 | 9. Birthplace (Ste Country) Washingt | on, DC | | |
| ad at | Usuel Residence of Decedent 10a. Stete 10b. County | 10c. | City, Town or Lo | cation | | | | | e City Limits | | |
| Director | Maryland Prince Ge | orge's C | | | | יטי | res 2 No | | | | |
| Olre | 10e. Street and Number | | | 1 | 0g. Citizen of V | Vhet Country? | | | | | |
| Ta E | 9014 Rhode Island | 9014 Rhode Island Avenue 20740 | | | | | | | | | |
| edeal Especial must be confined at letted by Funeral Director | 11. Meritel Stetus 1 Never Merried 2 Married 3 Widowed 4 Divorced | 12. Wes Decedent Ever if Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Yeer or Detes: | | Wes Decedent of If Yes, specify Cut 1 ☐ Yes 2 ☑ No | Hispanic Origin? (Span, Mexican, Puer Specify: | Specify Yes or No- to Rican, etc.) | | e - American Indiar k, White, etc. White | ١, | | |
| le P | 15. Decedent's Educ | e completed) (Give kind of work done during most of | | | | | 16b. Kind of Bu | siness/Industry | | | |
| Be Completed | (Specify only highest grade Elementery/Secondery (0-12) | College (1-4or 5+) | life. | DO NOT use retire | adining most of wo | nxing | | | | | |
| other traumatic event, tre Ma | 12 | | | Own Hor | ne | | | | | | |
| Se ven | 17. Fether's Neme (First, Middle, Last) | 18. Mother's Ne | me (First, Middle, I | Meiden Sumam | e) | | | | | | |
| 0 | Frank K. Stewart | | | | Katheri | ne (Unava | ilable) |) | | | |
| | 19a. Informant's Name/Reletionship (Ty) | | 19b. Mailir | ng Address (Stree | t and Number or R | ural Route Number | , City or Town, | Stete, Zip Code) | | | |
| 5 | William A. Barrack | - Nephew | 6437 | Fairbank | s Street | , New Car | rollton | n, MD 207 | 84 | | |
| 5 | 20a. Method of Disposition 1 🖾 Burlel 2 □ Cremetion 3 □ R | | b. Plece of Dispo cemetery, crer | sition (Name of metory or other ple | ece) | Deta | 20c. Location - | City or Town, Stete | 9 | | |
| | 4 □ Donetion 5 □ Other (Specify) | | edar Hi | 11 Cemet | ery (| 01/10/00 8 | Suitlan | d, Maryla | and | | |
| 8 | 21. Signeture of Funeral Service License | e / | 22 | . Name and Addr | ess of Facility | - | | | | | |
| 8 | 17 fort | York | | | | ome, P.A. enue, Hya | | I - MD 20 | 701 | | |
| | 23a. Pert1. Enter the disease, or complic | cetions that caused the d | | | | | | Approxi | mete | | |
| ian cat | shock, or haert tailura. List only on | Λ | | | | | | | Between and Death | | |
| ner . | disease or condition resulting in deeth) | Lung | Cer | ce | | | | 120 | flurs | | |
| 1 1 | | Due t | o (or es e consec | quence of): | | | | | | | |
| edical Examiner | a b | | | | | | | | | | |
| Xar | Sequentielly list conditions, if any, leeding to immediate | Due t | o (or as e consec | juance of): | | | | | | | |
| dical Examir | Cause (Diseese or Injury | | | | | | | | | | |
|) B | thet initiated events resulting in deeth) Last | Due to | o (or es a conseq | uence of): | | | | | | | |
| Š | | | | | | | | | | | |
| leted by Physician/M | | | | | | | | | | | |
| ys | Part II. Other algnificant conditions con | tributing to death but not | rasulting In tha u | nderlying cause g | iven in Part I. | 4 | | ntribute to the cau | | | |
| by Physician/M | Bladdle | of Canc | er | | | 1/200 | es 2 No | 3 Probably | 4 Unknow | | |
| Completed b | | F. 7. | 24a. Was a perform | | 24b. Were autor available pr completion of death? | ior to | | | | | |
| E | | | | | | 1 U Y | es 2000 | 1 ☐ Yes | 2 No | | |
| To Be Com | 25. Was case raterrad to medical | | Market N | | 26. Place of De | eth (Check only on | | | | | |
| To B | eveminer? | ospitel: | 2 ☐ ER/Outpatier | 1 3 DOA O | | Homa 5 ☐ Reside | | at (Specify) | | | |
| 1:1 | 27. Mannar of Death | 28e. Dete of Injury | 28b. Time of | | | 28d. Describe h | | | | | |
| 를 I | 12 Naturel 5 ☐ Pending Investigation | (Month, Dey Year | r) Injury | | Yes 2 No | | | | | | |
| Certification: | 3 Suicide 6 Could not be determined | treet and Numb n, Stete) | er or Rurel Route I | Vumber, | | | | | | | |
| Medical Certification: To | 29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and dua to the cause(s) and manner as stated. (Check only one) Check only one) | | | | | | | | | | |
| Me Me | 29b. Signeture and title of certifiar | | | 29c. Licen | se number | 2 | 9d. Date signer | d (Month, Day, Yes | ar) | | |
| | NO NULL 1 1 26492 | | | | | | | | | | |
| | 30. Nama and addrass of person who completed cause of deeth (Item 23a) (Type, Print) | | | | | | | | | | |
| | | | | | | | | | | | |
| | Riad Dakheel, M.D. 4000 Mitchellville Road #B-216, Bowie, Maryland 20716-3105 a 31. Dete filed (MIND) Yar 2000 32. Registrer's Signeture | | | | | | | | 3 | | |
| | | 32 Pagistrar's Si | | | | - | | | | | |

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene

| | | | | | | Cei | tificate | e of | Death | | | Reg. No. | | | |
|---|--|--|---|---|--------------------------------|--------------------------|------------------------|----------------|-----------------------------|-------------------------|--------------------------------------|------------------------------------|------------------------------|---|--|
| Physic | ion | 1. Decedent's Neme (First, Midd | lle, Last) | | | | | 11/4 | | | 2. Dete of De Month | Day | Year | 3. Time = Emath | |
| /Med | | SARAH SYMPRONI | IA SANDII | GE | | | | | | | JANUAF | RY 16, 2 | 000 | 9:42 AM | |
| Exami | iner | 4a. Fecility Neme (If not institution FORT WASHINGTO | 100000000000000000000000000000000000000 | | | | | | | | cation of Deat | PRINC | | RGE | |
| Funeral Director | | 5. Sociel Security Number 213-56-4530 | 6. Sex 1 □ M 2 1 F | 7. Age | e (In yrs. last 82 | birthdey) Yrs. | If Under Months | 1 Yeer Deys | | 24 Hrs. Min. | 8. Date of Bir (Month, De AUG. | th 19. Year) 15, 1917 | 9. Birthpl Count MARY | ece (State or Foreign (ry) LAND | |
| Aanyland f show | or | Usuel Residence of Decedent 10e. Stete 10b. County MARYLAND PRINCE | | | 10c. City, To | | cation | | | | | | 10 | 0d. Inside City Limits | |
| the the moth | Director | 10e, Street end Number | GEORGE | | ACCOL | CIII. | 10f. Zip | Code | | | | 10a. Citizen of V | Og. Citizen of Whet Country? | | |
| h with | | 17511 LIVINGSTO | ON ROAD | | | | | | 607 | | | UNITED | | | |
| 72 hours after deeth with the Manyland "natural", or thems 23s or 28s-f show at sall Examiner must be notified at | by Funeral | 11. Meritel Stetus 1 □ Never Merried 2 □ Mar 3 ☒ Widowed 4 □ Divorced | d 2 Married 1 Yes 2 No | | | | | | | | ecify Yes or No Rican, etc.) | 14. Rac Bled Specify | e - America k, White, e | etc. | |
| 2 hou | | 15. Deceder | nt's Education | | 10 | Be. Deced | ent's Usue | Occup | pation | | | 16b. Kind of Bu | siness/Ind | lustry | |
| d within giene. r than " | Completed | (Specify only higher Elementery/Secondery (0-12) 7TH GRADE | 1 | college (1-4or 5+) College (1-4or 5+) Give kind of work life. DO NOT use HOME MAI | | | | | | t of work | ing | PRI | VATE | | |
| ed it b | To Be | 17. Fether's Name (First, Middle, GEORGE W. MUNSC | | | | | | | | | e (First, Middle TTHEWS | , Meiden Sumen MUNSON | 10) | | |
| | | 19e. Informent'e Neme/Reletions DELORES SMITH / | | ER | | L6925 | OLD | MAR | SHALL | | | er, City or Town, ACCOKE | | | |
| 8027 | Department of Important: If it any Injury or one once. | 20a. Method of Disposition 1 Buriel 2 Cremetion 4 Donetlon 5 Other (5 | | om Stete | 20b. Plece ceme MARYI | | | | CEM. | 1 | Dete /21/00 | 20c. Location - CHELTEN | | m, Stete MARYLAND | |
| parmit. Pages 1 er Department of Hea Important: if item; any Injury or other | | 21. Signature of Funeral Service | southe & | 7-b | T M0058 | TH | ORNIC | N F | | T HO | ME, P.A | A. IAN HEAD | MD | 20640 | |
| | | 23a. Pert1. Enter the disease, or shock, or heart feilure. List | | | | - | | | | | | | , 140 | Approximete Interval Between | |
| bath certificate be axecuted attending physician and for use as the buriel-transit | 2 0 0 " | Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest | c | // | Due to (or es | e conseq | uence of): | lio | Vac | wla | Pole n Di | egase | | | |
| e death of the attention hed for u | Physician | Pert It. Other significant condition | ons contributing to | death bu | ut not resulting | g In the ur | nderlylng ca | ause gi | ven in Pert | l. | | | | the cause of death | |
| res that the igned by be detected | by Pt | | | | | | | | | | 10 | Yes 2□ No | 3 Prob | ebly 4 ☐ Unknow | |
| r requi | Completed b | | | | | | | | | | 24a. Wes | an autopsy ormed? | ava | re autopsy findings Illable prior to appletion of cause seath? | |
| 0 - 0 | mo: | | | | | | | | | | 10 | Yes 2 No | 1 | Yas 2□ No | |
| | Be | 25. Wes case referred to medica examiner? | | | | | | | | e of Deet | h (Check only | one) | | | |
| 0 0 | 10 | 1 ☐ Yes 2 No | | ☐ Inpatie | - | Outpetien | | A | | | | dence 6 Oth | |) | |
| tending leath. lor: After the fune | Certification: | 27. Menner of Deeth 1 Netural 5 Pendir 2 Accident investi 3 Sulcide 6 Could | igetion not be | te of Injur Ionth, Day | | o. Time of Injury | М | | ryat vrk?]Yes 2□ | No | | how injury occur | | | |
| in Sign | Certifi | 4 Homicide | nined 269. Pla | ace of Inju ilding, etc | iry - At home, :. (Specify) | , farm, str | et, fectory | , office | | | 28f. Location (City or To | Street and Numb wn, Stete) | er or Rura | l Route Number, | |
| To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by | edical | 29e. Certifier (Check only one) 1 Certifyir 2 Medicat | ng Physician: To t Examiner: On the end m | the best of basis of enner sta | examinetion | lge, deeth end/or inv | occurred a estigetion, | it the ti | me, dete er opinion, dee | nd plece, oth occurr | and due to the red at the time, | cause(s) end me date and plece, | enner as st and due to | ated. the cause(s) | |
| To the To the Comp | Σ | 29b. Signeture end title of certifie | er . | | ^ | | 29c | - | se number | | | 29d. Date signe | d (Month, L | Dey, Year) | |
| | | 1 Rosan | à Fles | non | do | | | | 7518 | | | JANUARY | | | |
| | | 30. Neme and address of parson 7700 040 BRANC | thit c | ause of de | LINTS: | a) (Type, | | | OLD E | | | JE, SUIT 1735 | E C-1 | .02 | |
| St. Regist | ate rar | 31. Dete filed (Month, Dey, Year) JAN 1 | 9 2000 | . Registre | er's Signeture | B. | de | rous | 61 | | | | | | |



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month January 6, 2000 5:15PM Anne L. Stein 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (II not institution, give street and number) Suburban Hospital Bethesda Montgomery If Under 24 Hrs. 8 Dete of Birth (Month, Day, Year) If Under 1 Year 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Days Months 1 M 207 219.42.3371 83 21,1916 Pennsylvania July Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15115 Interlachen Dr. #325 20906 United States 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Giva Year or Detes: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: 3 ☐ Widowed 4 ☑ Divorced White 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Neme (First, Middle, Last) 18 Mother's Name (First Middle Maiden Surname) Morris Lean Fannie Stein 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marc Stein/Son 6338 Montrose Rd. Rockville, MD. 20852 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from Stete 4 ☐ Donation 5 ☐ Constitution (Constitution) 01/10 Olney, MD. Judean Memorial 22. Name and Address of Fecility Stein Hebrew Funeral Home. al Sarvior Lie 21. Signeture of Fu 232 Carroll the St. NW. Washington, DC.20012 of disease, or complications that caused the death. Do not entar the mode of dying, such as cardiac or respiratory arrest, an feiture. List only one cause on each line. Approximete Intervel Between Onset and Death Immediate Cause (Finel Sacral decubitus ulcer disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as e consequence of): Dua to (or as a consequence of): Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24e. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No 25. Was casa referred to medical examiner? 28. Plece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No

Examin physician and the burlei-transit Records, Vital

Physician/Medical þ Completed Be

27. Manner of Death

1 DiNetural

2 Accident 3 Suicide

4 ☐ Homicide

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)
JAN 1 0 2000

29a. Certifier

5 Pending

6 Could not be

Medical Certification: To e Hospital or Attending n 24 hours after death. ne Funerel Director: Afte

Physician

/Medical

Examiner

Funeral

Director

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ms 23s or 28s-f short

"natural", or items

permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hyglenn. Important: If New 27 is marked other than "natural", or New eny Injury or other traumatic event, the Medical Permit

Physician /Medical

Examiner

altimore. Maryland 21215-0020

Directo

Funeral

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ompleted

deeth with the Manyland

To the Hosp within 24 ho To the Fune completely fi

Registrar

ellie MA

28a. Date of Injury (Month, Day Year)

1 TYes 2 No

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, data and plece, and due to the cause(s) and menner stated.

29c. License number
D53244

29d. Date signed (Month, Day, Year)

January 6, 2000

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Katharine R. Lillie, MD 11140 Rockville Pike, #348, Rockville, MD 20852

28d. Describe how Injury occurred

32 Registrar's Signature bouch

28b. Time of

28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

0005 0 I WAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMENDED ITEM #19b PER FH G780 2/1/2000 AH Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Data of Deeth 3. Time of Death Year Month **Physician** D. Henry Sheitelman January 6,2000 12:30AM /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) 4c. County of Deeth **Examiner** 7104 Adelphi Hyattsville Rd. Prince George If Undar 1 Yaar 8. Data of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** Days Hours Months 10 M 20 F Yrs. Director 051-09-5676 Jan. 31, 1914 New York, NY Usual Residence of Dece Manhand 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County must be notified at 1 Yes 2 No Maryland Prince George Director Hyattsville å 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or flams 23a or 7104 Adelphi Rd. 20782 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, 12. Wes Decedent Ever in U,S. Armed Forces? Black, White, etc. filed within 72 hours after 1 ☐ Yes XXNo If Yes, Give 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: þ 3 Widowed 4 Divorced Year or Dates: White Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) 5+ Electronic Engineer U.S. Army permit. Pages 1 and 2 should be file Department of Health and Mental Hyg Important: It lean 27 is marked other any Injury or other traumers other pages. 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be To Abraham Sheitelman Masha Bedson 19a. Informent's Neme/Reletionship (Type, Print) 19b, Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 7401 Adelphi Rd. Hyattsville, Md 20782 Claire Sheitelman / Wife 20b. Plece of Dispusition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stata Jan 7 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removal from Stete Judean Memorial Gardens2000 Olney, Maryland 5 ☐ Other (Specify) 4 Donation 21. Signature of Funeral Service Connece Markette Been jamin M. Marthews 22. Nema and Address of Fecility Stein Hebrew Memorial Funeral Home Beatlanin M. Matthews

232 Carroll St. NW. Washington, shock, or heer tailure. List only one cause on each line. 20012 DC Approximata Interval Between Onset end Deeth **Physician** /Medical Immediate Cause (Finel Adenocarcinoma of Pancreas diseese or condition resulting in deeth) Examiner Due to (or as a consequence of): Examiner physician and the burial-transit the death certificate be asscuted Sequentially list conditions, if any, leading to immediate cause. Enter Undarlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical Dua to (or as a consequence of): for use as signed by the a d be detached f Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yas 2 No 3 Probably 4 Unknown þ Records. 24b. Were autopsy findings available prior to Completed 24a. Wes an autopsy performed? completion of cause of deeth? s certificate has b 1 ☐ Yes 2 1 No 1 ☐ Yes 2 ☐ No Division of Vital Attending Physicien: director. 25. Was case referred to medical Be 26. Place of Deeth (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Pesidence 8 Other (Specify) 1 Yes 2 No Certification: To this funeral 27. Menner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending 1 Netural death. 1 Yas 2 No n 24 hours after death.

Ne Funeral Director: A pletely filled in by the fi investigation 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 | Homleide 8 Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the bests of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. 29a. Certifier To the Hosp within 24 hor To the Fune completely fi (Check only one)

State

Registrar

31. Deta filed (Month, Dey, Year)
JAN 1 0 2000

30. Name and address of person who Mark Eig, MD

29b. Signatura a

32. Registrar's Signature

d cause of death (Item 23a) (Type, Print)

10801 Lockwood Dr. Silver Spring, Maryland

29d. Date signed (Month, Dey, Year)

January 6, 2000

DHMH 16 Rev 6/95

29c. License number

D24886

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month MARTHA MILDRED ST. CLAIR January 15,2000 5:50 PM 4b. City, Town, or Location of Deeth 4c. County of Death 4a Fecility Name (If not Institution, give street and number) La Plata Charles Genesis Elder Care If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 10M 2OF 89 Yrs. February 9,1910 Maryland 216-68-7643 Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limita MD Charles La Plata 1 ☐ Yes 2 No 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 20646 USA One Magnolia Drive 13. Was Decedent of Hispanic Origin? (Specify Yea or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Rece - American Indian, Black, White, etc. 11. Maritel Stetus 1 ☐ Yes 2 XNo If Yes, Give Yeer or Detes: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No 3 Widowed 4 Divorced white 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 6 N/A N/A17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Addison St. Clair Helen Simpson St. Clair 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 11450 Asbury Cir. Apt. 222 Solomns, MD20688 Archie St. Clair/Brother 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 20c. Location - City or Town, State 4 □ Donetion 5 □ Other (Specify) Metropolitan Crematory1/18/00 Alexandria,VA. AREHART-ECHOLS FUNERAL HOME, P.A. 21. Signety of Funeral Service Licensee M00945 Echolo P.O. BOX 567 LA PLATA, MD 20646 23a. Pert1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cerdiac or respiretory errest, Approximate Intervel Between rvel Between Onset and Deeth Immediate Ceuse (Finel disease or condition resulting in death) Due to (or es e consequ 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 450 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy tindings aveileble prior to completion of cause ot death? 24e. Wes an autopsy performed? 1 Yes 1 ☐ Yes 2 ☐ No 26. Place of Deeth (Check only one)

Physician /Medical Examiner

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Hospital 24 hours Funeral

funeral

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Certification:

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that the death certificate be exec

Division of Vital Records.

Physician

/Medical

Examiner

Funeral

Director

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ir than "naturel", or items 23s or

permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturef", or itel any injury or other treumetic event, the Medical Example 00.08.

altimore, Maryland 21215-0020

Directo

Funeral

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Completed

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death .

Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting In death) Last ician/Medical

25. Was cese referred to medical examiner? 1 Yes 2 No 27. Manner of Death Netural Accident 5 Pending Investigation

6 Could not be determined 3 Suicide 4 Homicide

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28e. Date of Injury (Month, Dey Year) 28b. Time of

28e. Place of Injury - At home, tarm, street, tactory, office building, etc. (Specify)

28c. Injury at Work? 1 ∏Yes 2 ∏No

Other: Ursing Home 5 Residence 6 Other (Specify) 28d. Deacribe how injury occurred

28t. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only

ng Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end manner as stated.

Ical Examinar: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end manner stated.

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

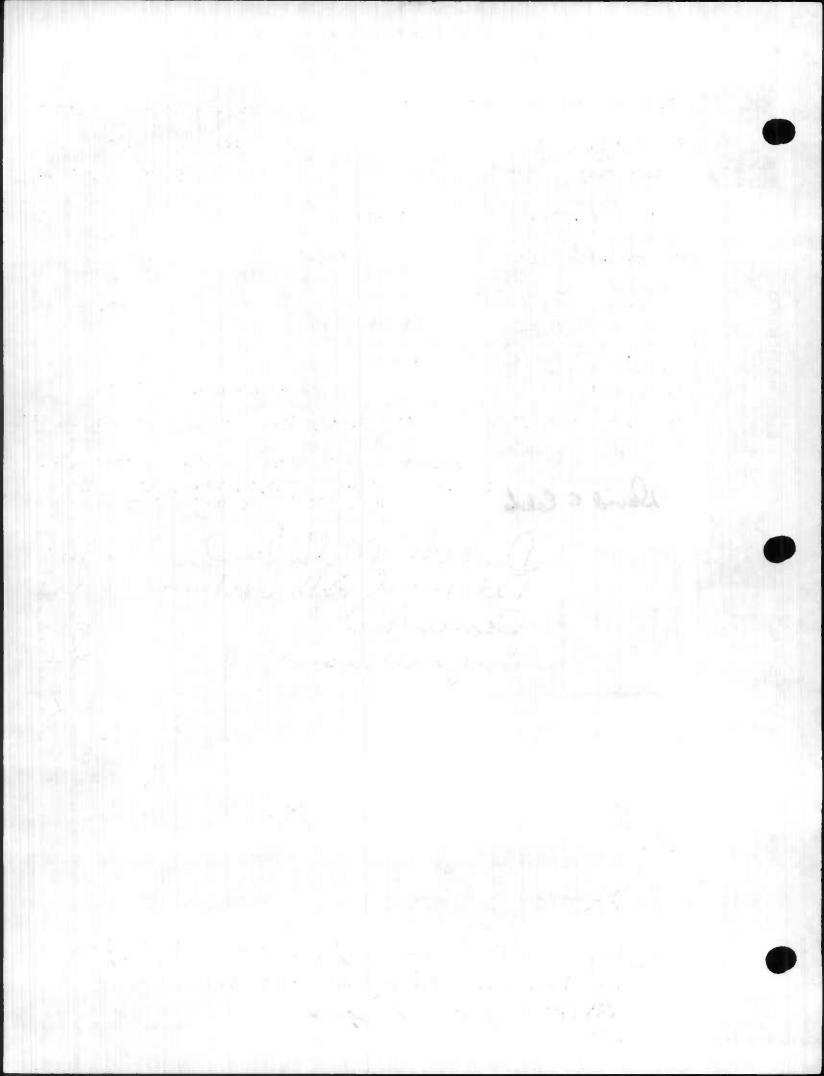
to completed ceuse of death (Item 23a) (Type, Print)

ATTERON M.O.

State Registrar

32. Registrar's Signeture 2000 8

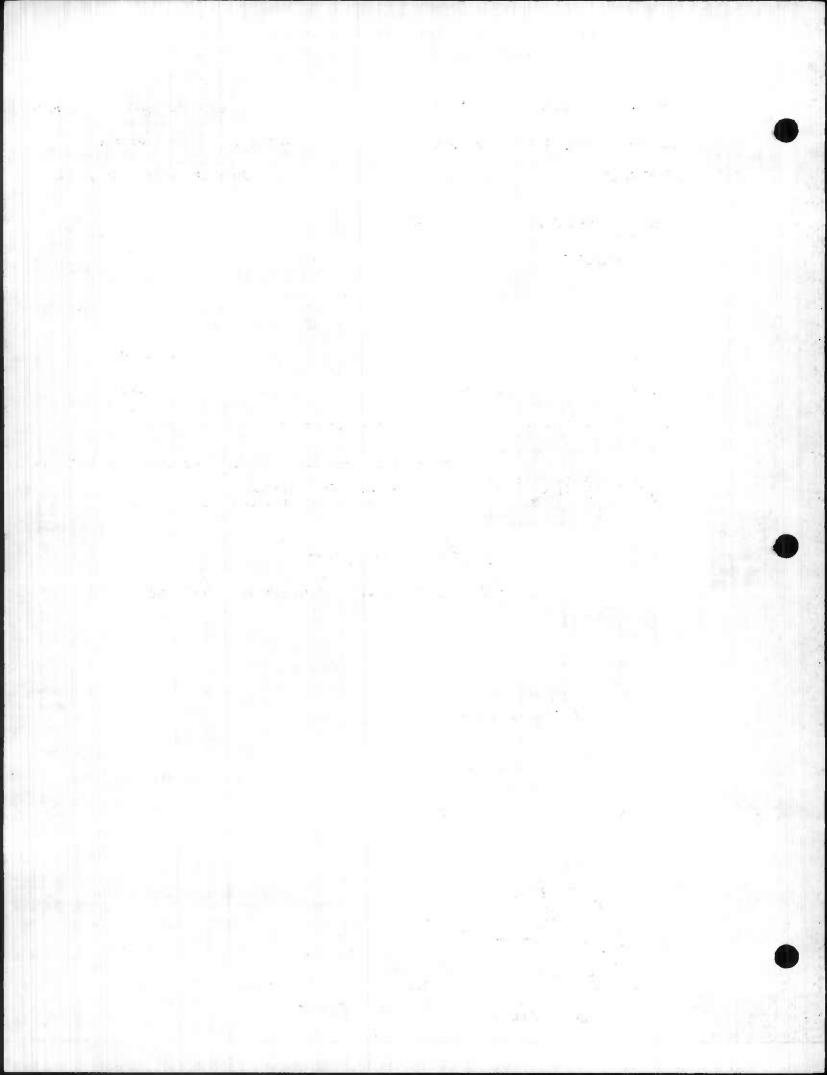
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State of Maryland / Department of Health and Mental Hygiene

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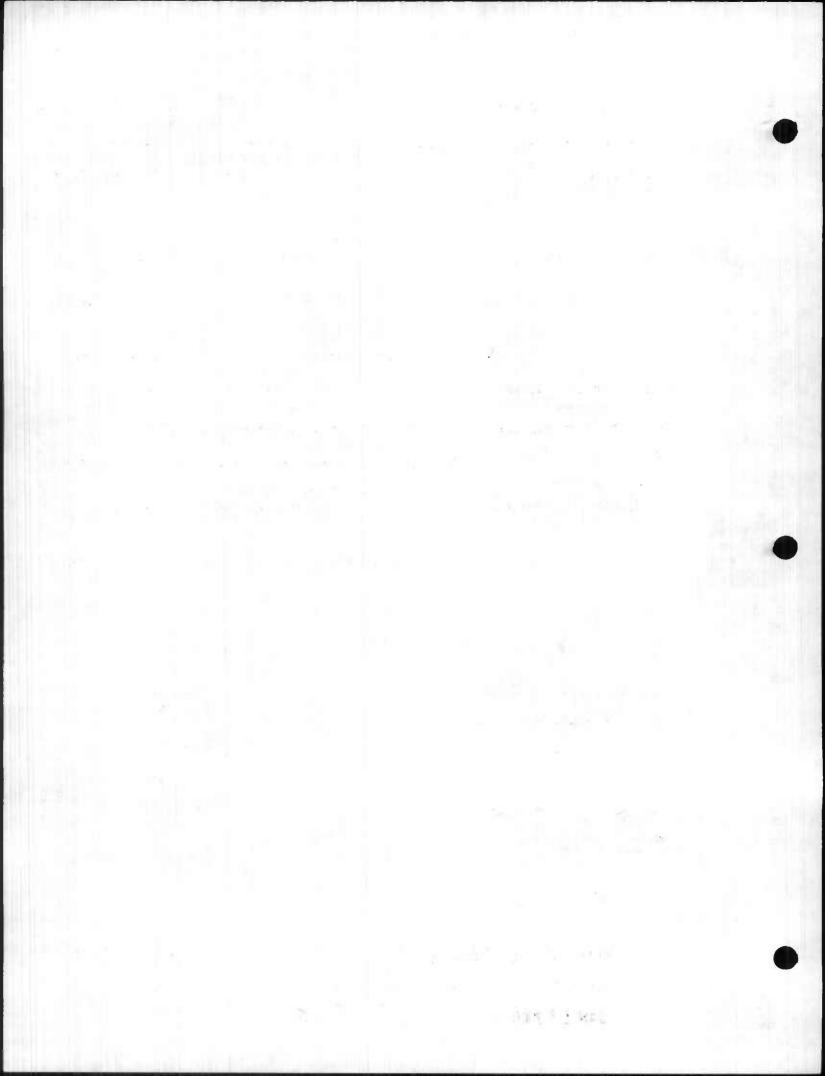
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not anter tha mode of dying, such as cardiac or respiratory arrest, interval Between Onset and Death Physician Medical Examiner Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying to mediate c | | | | | | | (| ertit | icate of | Death | | | Reg. No. | | | |
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| PRIVICION Medical Examiner Part II. Other significant conditions contribute to the cause of death of the contribute of the cause of death of the contribute of the cause of death of the cause of d | | | 23a. Part1. Enter th | e disease, or con | plications that | caused the de | ath. Do no | | | | | | | | App | roximata rval Between |
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State of Maryland / Department of Health and Mental Hygi

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| | | | Certificate o | f Death | R | eg. No. | 06000 | | | | |
|---|--|--|---|---|--|--------------------|--|--|--|--|--|
| | Decedent's Name (First, Middle, Last) | | | | 2. Date of Deat Month | | 3. Time of Death | | | | |
| Physician /Medical | George Shirley STE | VART | | | Jan. | 14, 200 | 3:10 PM | | | | |
| Examiner | 4e Facility Name (If not Institution, give street ar | d number) | | 4b. City, Town, or Le | ocation of Death | 4c. County of | Death | | | | |
| | Garrett County Memor: | ial Hospital | | Oakland | | Gar | rett | | | | |
| Funeral | 5. Social Security Number 6. Sex | 7. Age (In yrs. last I | birthday) If Under 1 Yes Months Dev | | 8. Dete of Birth (Month, Day, | Year) 9 | Birthplace (State or Forei Country) | | | | |
| ther than "natural", or items 23a or 28a-f show ther than "natural", or items 23a or 28a-f show and the Modest Examiner must be notified at completed by Funeral Director | 162-16-8676 Usual Residence of Decedent | 81 | Yrs. | | Aug. 9, | | Maryland | | | | |
| 8 = | 10a. State 10b. County | 10c. City, To | own or Location | | | | 10d. Inside City Limi | | | | |
| to to | MD Garrett | | 0akland | | | | 1 1 Yes 2 □ N | | | | |
| be notified Director | 10e. Street and Number | | 101. Zip Code | | 1 | 0g. Citizen of Wh | at Country? | | | | |
| O D | 603 E. Reese Street | | | 21550 | | USA | | | | | |
| Funeral | 11. Marital Stetus 12. Wes | Decedent Ever in U,S. | 13. Was Decedent o | f Hispanic Origin? (Spuban, Mexican, Puerto | ecity Yes or No- | | American Indian, | | | | |
| by | 1 Never Married 2 Married 1 X | ed Forces? Yes 2 No s, Give WW II | 1 ☐ Yes 2 ☒ N | | Hican, etc.) | Specify: | White, etc. White | | | | |
| traumatic avant, the Medical | 15. Decedent's Education (Specify only highest grade comple | 16 | Se. Decedent's Usual Occ (Give kind of work don life. DO NOT use reti | supation | ina | 16b. Kind of Busin | ness/Industry | | | | |
| Completed | | ege (1-4or 5+) | life. DO NOT use reti | red) | "ig | | | | | | |
| 00 | 12th | | Clerk/Mana | ger | | Grocer | y Store | | | | |
| Be | 17. Father's Name (First, Middle, Last) | Maiden Sumame) | | | | | | | | | |
| To | 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) | | | | | | | | | | |
| | Harrison Blaine Stewart, I Sylvia Lavina Shirley 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, | | | | | | | | | | |
| | Jennie M. Stewart/Wi | Ee 6 | 03 E. Reese | St., Oakl | and, Md | . 21550 | | | | | |
| redto | 20a. Method of Disposition | 20b. Plece | of Disposition (Name of tery, crematory or other p | | | 20c. Location - Ci | ty or Town, State | | | | |
| ry or othe | 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal 4 ☐ Donation 5 ☐ Other (Specify) | from State | tt Co. Mem. | | /17/00 | Oakland | . Maryland | | | | |
| any Injury o | 21. Signature of Funeral Surviva Licercian | 6 | 22. Name end Add | | 7 2 7 7 0 0 | 001120110 | , 11012) 2.0110 | | | | |
| SDC ST | DO 10 10 | | Stewart | Funeral H | lome | | | | | | |
| | Busiley A - Ally | bhat saysand the death. D | 32 S. S | econd St., | Oakland | d, Md. 2 | 1550 Approximate | | | | |
| | 23a. Part1. Enter the disease, or complications shock, or heart failure. List only one cause | on each line. | O HOL BIRDI (HE HICOS OF C | lying, such as caldiac | or respiratory and | 031, | Interval Between Onset and Deeth | | | | |
| ian cal | Immediate Cause (Final | | | | | | | | | | |
| er | disease or condition resulting in death) | Myocardia | 1 Infarctio | n | | | Days | | | | |
| 1 | , | Due to (or as | e consequence of): | | | | | | | | |
| Examiner | b | | | | | | | | | | |
| хап | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or Injury c | Due to (or es | a consequence of): | | | | 1 | | | | |
| | cause. Enter Underlying Cause (Disease or Injury | | | | | | i | | | | |
| edicai | that initiated events resulting in death) Last | Due to (or as | a consequence of): | | | | | | | | |
| Medical Examir | d | | | | | | | | | | |
| Physician/M | Part II. Other significant conditions contributing | to death but not resulting | in the underlying cause | given In Part I. | 23b. Dld to | obacco uaa contr | ibute to the cause of deat | | | | |
| hy | | | | | 1 🗆 Y | 08 X No 3 | Probably 4 Unknow | | | | |
| by Physi | Congestive Hear | Failure | | | | | | | | | |
| | Renal Failure | | | | 24e. Wes a | | 24b. Were autopsy finding available prior to | | | | |
| Completed | Wellar ratifule | | | | potion | | completion of cause of death? | | | | |
| Comp | | | | | 1 🗆 Y | es 2 No | 1 ☐ Yes 2 ☐ No | | | | |
| Ü | 25. Was case referred to medical | | | 26. Place of Deal | | () | | | | | |
| lo Be | examiner? | Manation of the | Outpation: all post | Where | | enca 6 Other | (Specify) | | | | |
| | 1 ☐ Yes 278 No 27. Menner of Deeth 28a. | Date of Injury 28t | Outpatient 3LI DOA | 4 LI Nuising Fit | | ow injury occurred | | | | | |
| Certification: | 1 Wetural 5 ☐ Pending | (Month, Day Year) | Injury V | Vork? ☐ Yes 2☐ No | | | | | | | |
| Medical Certificat | 3 Sulcide 6 Could not be | Place of Injuny - At home | farm, street, factory, offic | | 28f. Location (S | treet and Number | or Rural Route Number, | | | | |
| Ē | | building, etc. (Specify) | | City or Town | | | | | | | |
| | | | | | | | | | | | |
| edicai | 29a. Certifier (Check only one) Certifying Physician: T Medical Examiner: On end | o the best of my knowled the besis of examination menner stated. | ge, death occurred at the and/or investigetion, in m | y opinion, death occur | and due to the c red at the time, d | iate and place, an | ner as stated. Indicate to the ceuse(s) | | | | |
| N N | 29b. Signature and title of cartifier | | 29c. Lice | ense number | 2 | 29d. Date signed | (Month, Day, Year) | | | | |
| | DAD TO | 00 0 | | H26154 | | 111= | 17000 | | | | |
| | - Lames M | Me & | e | п20134 | | 1/13 | 12000 | | | | |
| LIVA | 30. Name and address of person who completed | | | | | 01555 | | | | | |
| 8+IVA | Dr. P. Daniel Miller, | | 1f Acres Dr | ive, Oakla | nd, MD | 21550 | | | | | |
| State | 7 - | 32. Registrar's Signeture | 6 1 | 1 | | | | | | | |
| egistrar | JAN 1 8 2000 | 145-40 | 10. 100 | all! | | | | | | | |



State of Maryland / Department of Health and Mental Hygiene

of Death

| | - | | | | - | |
|---|----|-----|-----|-----|---|---|
| 2 | 00 | 0 | 0 | 0 | 0 | 0 |
| 3 | | 1.1 | / | - 1 | - | |
| | 00 | 0 | 1 . | 1) | 1 | 1 |
| | | | | | | |

| | | Certificate |
|--------------------|---------------------------------------|-------------|
| | Decedent's Name (First, Middle, Last) | |
| Physician /Medical | Mildred Verta Sweitze | er |

2. Dete of Death Month 3. Time of Death Day 17, 2000 2:30A.M. Jan.

Exami

Funerai Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mantal Hygiena. Important: If Item 27 is merked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, if a Maryland Explicit control once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be associated within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

| er | 4a. Facility Name (| If not instituti | ion, give street | end numb a | er) | | | | 4b. City, T | own, or L | ocation of Daal | th 4 | c. Count | y of Dea | ith |
|-------------------------|--|-----------------------|------------------------------------|---------------------------|--------------|---------------|--------------------|--------------|----------------------|------------|---------------------------------|--------------|---------------|----------|--|
| | Garret | t Cou | nty Me | emori | lal H | lospi | tal | | Oak | lan | d | (| Garr | ett | |
| | 5. Social Security N | lumber | 6. Sex | | Aga (In yrs. | lest birthday | | der 1 Yaar | | | 8. Date of Bi | rth | -1 | 9. Bit | thplace (Stete or Foraign ountry) |
| | 213-72-44 | 449 | 1 □ M 2 | ∑ F | 80 | Yrs. | Montl | hs Days | Hours | Min. | Oct. 5 | ey, Yea | 919 | | RYLAND |
| | Usuel Residence o | f Decedent | | | | | | | | | 0000 |). I | 717 | 11111 | CLDINIO |
| | 10a. State | 10b. Count | ty | | 10c, Cit | ty, Town or I | Location | | | | | | | | 10d. Inside City Limits |
| tor | MD | GAR | RETT | | | K | ТТИМ | ILLER | | | | | | | 1 ☐ Yes 2X No |
| rec | 10e. Street and Nu | | ILD I I | | | | T | Zip Code | | | | 10g. C | itizen of | What C | ountry? |
| | E / 73 | | n 1 | | | | | | 01500 | | | | ** | 0 4 | |
| 6 | 54 Hard | lesty. | | as Deceder | nt Ever in U | I.S. 13 | Was De | | 21538 Hispanic Or | | ecify Yes or No | 3- | | S.A | A . arican Indian, |
| Funeral Director | 1 ☐ Never Marr | ied 2□ Me | Ar | med Forces | s? | | If Yes, s | pecify Cut | oan, Mexica | n, Puarto | ecify Yes or No Rican, etc.) | | | ck, Whi | |
| by | 3 X Widowed | | . If | Yas, Giva ear or Dates | | | 1 🗆 Yas | 2 X No | Specify | 7 | | | Specia | | |
| Completed by | | 15. Decede | ent's Education | | | 16a, Dec | edent's Li | sual Occu | pation | | | 16h | Kind of F | | HITE /industry |
| olet | | cify only high | ast grade com | pleted) | | (Giv | e kind of DO NO | work done | during mo | st of work | ring | 100. | THIS OF E | daniosa | · · · · · · · · · · · · · · · · · · · |
| E O | Elementary/Seco | ondary (0-12) | Co | ollege (1-4o | r 5+) | | | usewi | | | | | | Home | |
| C | 17. Father's Name | (First, Middle | e, Lest) | | | | 1100 | TACAT | T - | er's Nam | e (First, Middle | . Meide | | | • |
| o Be | 7-1 | | DE | T73 (A 3.T | | | | | | | | | CTM | | |
| F | John 19a. Informent's N | ame/Relation | | EMAN | | 19h Mai | lling Addr | acc (Stran | Lucy | | rel Route Numb | or City | SIM | - | Zin Codol |
| | | | | | | | | | | | | | | | 21p C000) |
| | Delores A | | son/ Da | ughte | | Plece of Disp | | | Te KD | , va | kland, | | | | Town, State |
| | 1 ₹ Buriai 2 | ☐ Cramation | 3 Remov | al from Stat | - | cemetery, cr | emetory o | or other ple | ece) | | | | | | |
| | 4 Donation | | | | De | eer Pa | | | | | | | | | Maryland |
| | 21. Signature of Fu | neral Service | e Licensee | | | | | | ess of Facil | | STEWART | | | | |
| | Bus | Den | M WO | way | | | 32 | S. S | econd | St. | , Oakla | nd, | MD | 2155 | 50 |
| | 23a Part1. Enter t | he disease, o | or complication st only one cau | s that causes | ed the deat | h. Do not e | nter the n | node of dy | ing, such es | s cerdiac | or respiratory a | rrest, | | | Approximate Interval Batwaen |
| | | | , | | | | | | | | | | | | Onset and Death |
| | Immediate Cause diseasa or condition | | 7 | Cute | Ren | al Fa | ailu | ra | | | | | | | 18 Hours |
| | resulting in deeth) | | 8. 4 | 10000 | | or es e cons | | | | | | | | | 10 Hours |
| Examiner | | | | Conge | | e Hea | | | lure | | | | | | Years |
| ше | Sequentially list co | nditions. | D | | - | or as a cons | | - | | | | | | | - 0425 |
| EX | Sequentially list co if any, leading to in cause. Enter Unde Ceuse (Disease or that initieted events | nmediate orlying | | Coron | ary | Arte: | ry D | isea | ase | | | | | | Years |
| Ica | that initieted events resulting in death) | injury i S Last | C | | Due to (o | r as a conse | equence o | of): | | | | | | | 1. |
| Wed | Tooland an accuracy | 2001 | | | | | | | | | | | | | |
| Physician/Medical | | | d | | | | | | | | | _ | | | <u>I</u> |
| sici | Part II. Other signif | lcant condit | tions contributi | ng to death | but not res | uiting in the | underlyin | g cause gi | iven In Part | l. | 23b. Did | tobacc | o use co | ntribut | to the cause of death? |
| hy | m | - D · | 1 . | | 201 | | | | | | 10 | Yes | 2X No | 3 🗆 F | robably 4 Unknown |
| | Type | II Di | abetes | s Mel | litu | S | | | | | | | | | |
| Completed by | Chron | ic Re | nal Fa | ailur | e | | | | | | 24e. Was | an autormad? | opsy | 24b. | Were autopsy findings available prior to |
| plet | | | | | | | | | | | poin | Unneur | | | complation of causa of death? |
| mo | | | | | | | | | | | 10 | Yes : | 2 X No | | 1 ☐ Yas 2X No |
| Be C | 25. Was case refer | red to medic | al | | | | | _ | 26 Diag | o of Door | h (Check only | | - M 140 | | 1 1 1 1 1 2 2 A 1 1 1 0 |
| ToB | examiner? 1XYes 2□ | | Hospita | il: 1 🔯 Inpa | tient 2 | ER/Outpatio | ent 3 | DOA Ot | hor | | ome 5 Real | | 6 DO | or (En | noife) |
| T:U | 27. Manner of Deat | | 288 | . Date of In | jury | 28b. Time | of | 28c. Inju | | ursing ric | 28d. Describe | _ | | | outy) |
| tloi | 1 Anatural 2 Accident | 5 Pend | ing tigation | (Month, E | ay Year) | injury | М | | ork?]Yes 2.[. | No | | 1 | | | |
| flca | 3 Suicide | 6 Could | not be | . Place of I | niury - At h | ome, farm, s | treet, fac | tory, office | | | 28f. Location (| Street e | and Num | ber or A | lural Route Number, |
| erti | 4 🗌 Homicide | deter | illinoo | building, | etc. (Specif | y) | | , | | | City or To | wn, Ste | te) | | |
| C | 29a. Certifier | 10X Certify | ing Physician: | To the hes | t of my kno | wledge des | ith occurr | ed at the ti | ime dete si | nd place | and due to the | causo/ | e) and m | anner a | e etated |
| edical Certification: | (Check only one) | 2 Medica | i Examiner: O | n the basis | of examine | tion end/or I | nvestigati | ion, in my | oplnion, de | eth occur | red at the time, | date ar | nd pleca, | and du | e to the cause(s) |
| Me | 29b. Signature apd | in of cartifi | 1 | | | | | 29c. Licen | se number | | | 29d. D | ate sign | d (Mon | th, Qay, Year) |
| | b /1 | Ster | 100 | 11. | | | | DOOS | 33464 | | 34 | | 1 | | 10 |
| | 1/ | -Com | Logi | / / | 20 | | | נטטע | 55404 | | | | 11 | 17 | 10.0 |
| | 30. Name and address | | n who complete | | | | | | | | | | , , | | |
| | Robert | M. C | oughl: | ın, M | 1.D. | PO | Box | 8, I | Eglor | 1, W | V 267 | 116 | | | |

DHMH 16 Rev 6/95

State

Registrar

31. Date filed (Month, Day, Year)

32. Registrans Signature

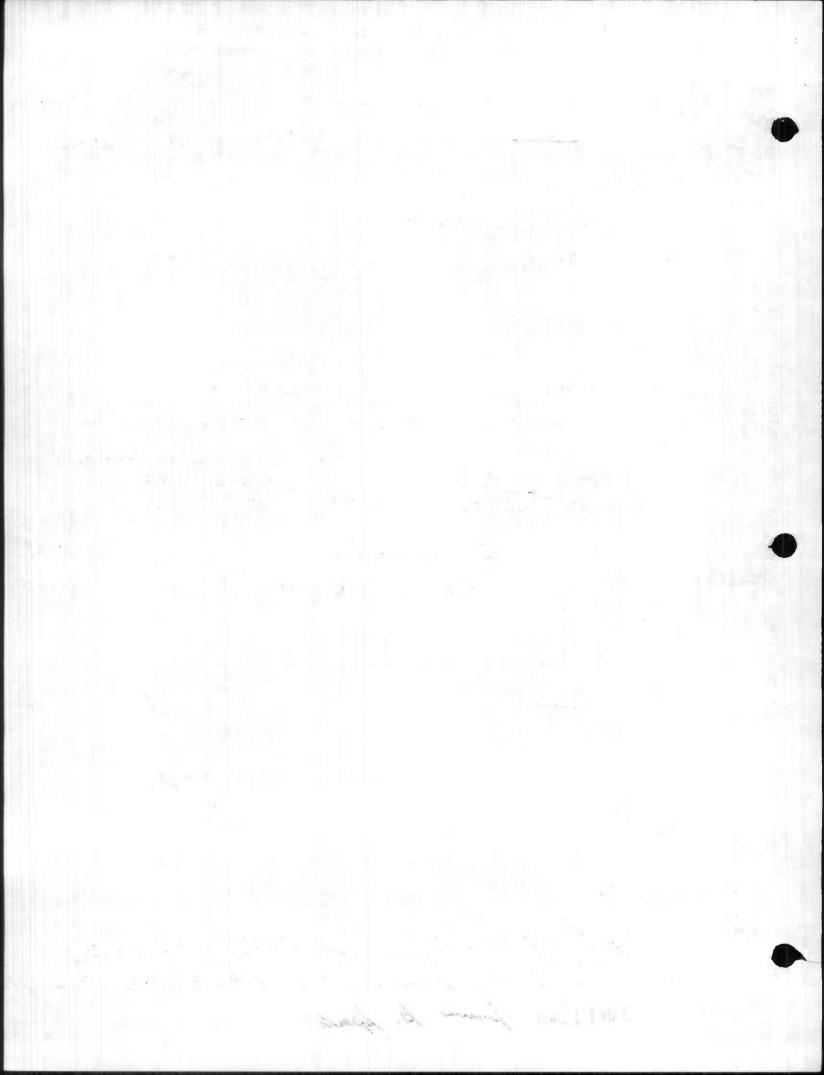
JAN 1 9 2000 >

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. Amended Item 4a, per Phy. State of Maryland / Department of Health and Mental Hygiene 1/11/2000, Carroll County, wjl Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Deta of Deeth 3. Time of Deeth Month **Physician** /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4a Facility Nama (If not institution, giva street and number) Examiner westmingler, ND. 524 S. Frizzelburg Road avol 7. Aga (In yrs. last birthday) If Under 1 Year I tf Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sax **Funeral** 1□M 2\ F Months Deys Yrs. Director 218-19-2582 Dec. 13, 1986 Maryland Usual Residence of Decedent with the Maryland 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show 1□Yes 2No Director Maryland Carroll Westminster 10e. Street and Number 10f. Zip Coda 10g. Citizen of Whet Country? ir than "naturel", or items 23s or the Medical Examiner must be a Peges 1 and 2 should be filed within 72 hours after death nent of Heelth and Mental Hygiene.
This if them 27 is marked other than "naturel; or thems 23 mry or other traumatic event, the Medical Exercise mustry or other traumatic event, the Medical Exercise must by or other traumatic event, the Medical Exercise must be set to the set to the must be set to the set to th Funerai 524 S. Frizzelburg Rd. 21158 12. Wes Decedent Ever In U.S. Armed Forces?

1 ☐ Yes 2 ဩ No If Yes, Give Yeer or Detes: Was Decedant of Hispanic Orlgin? (Specify Yas or No-It Yes, specify Cuben, Mexican, Puerto Rican, atc.) 14. Rece - American Indien. Black, Whita, etc. 1 Never Merried 2 Merried 3altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surnama) Byron D. Stambaugh Deborah Rodkey 19e. Informent's Name/Reletionship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Byron D. Stambaugh/father 524 S. Frizzelburg Rd. Westminster, MD 21158 20b. Plece of Disposition (Name of cematery, cremetory or other plece) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 Burial 2 Cremetion 3 Removal from Stata Department of Important: If any injury or 4 ☐ Donetion 5 ☐ Other (Specify) Paul's Lutheran Cem. 1/13/2000 Uniontown.MD 22. Name end Address of Fecility Hartzler Funeral Home Union Bridge, MD 21791 6 E. Broadway is that caused toe death. Do not enter the mode of dying, such as cardiac or respiretory errest, Approximate Interval Between Onset and Death 23e. Per/1. Enter the disease, or complications that caused to shock, or heart failure. List only one cause on each line. **Physician** Immediate Ceuse (Final diseesa or condition resulting in death) /Medical eumoni **Examiner** Examiner physicien end the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last Due to (or as a consequence ot): Division of Vital Records, P.O. Box 68760, the death cartificate be Physician/Medical Due to (or as e consequence of): 80 950 signed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown by 24b. Were autopsy findings sveileble prior to Completed 24a. Wes an eutopsy performed? completion of cause of death? page 2 s 1 Yes 2 No or Attanding Physician: director, Be 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one Other: 4 Nursing Home Certification: To 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 Other (Specify) uneral 28d. Describe how injury occurred 27. Menger of Death 28b. Time of 28e. Date of Injury (Month, Dev Year) 28c. Injury et Work? 1 Naturel
2 Accident 5 Pending investigation 1 Yes 2 No efter death Director: 6 Could not be determined 3 Sulcide Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 124 hours Hospital 12 Cartifying Physician: To the best of myknowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

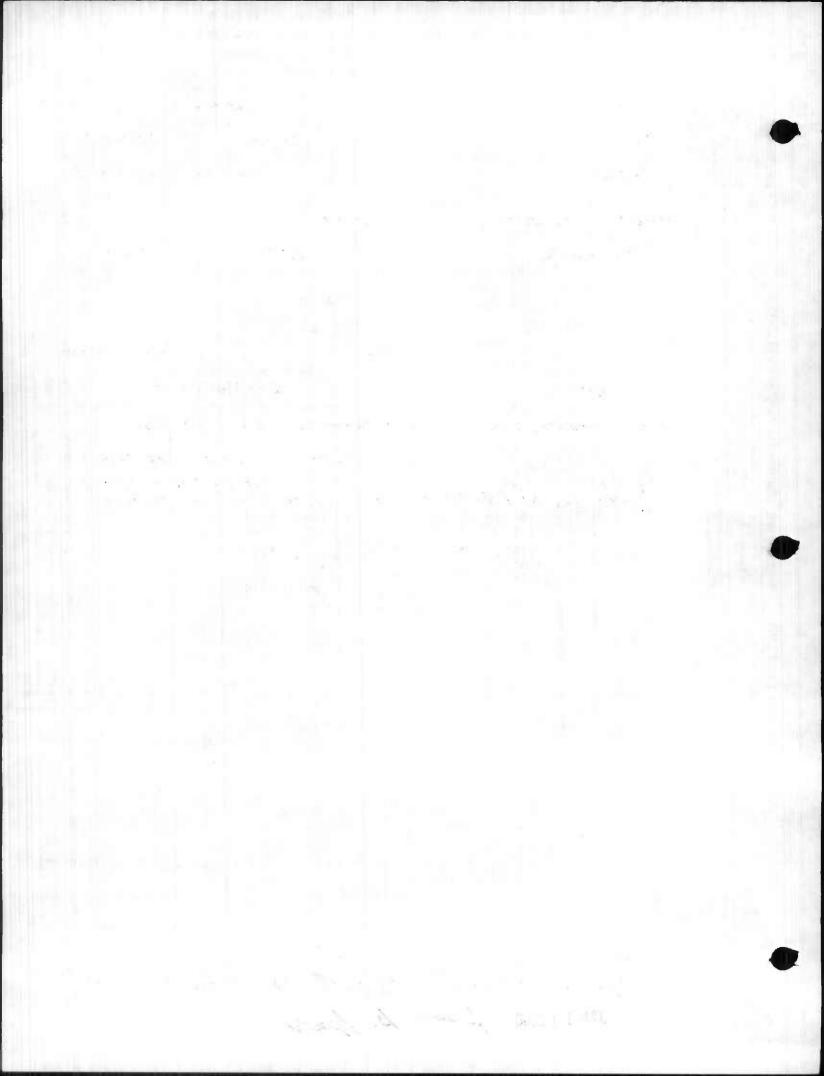
2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edicai To the Hosp within 24 ho To the Fune completely fi 29b. Signeture and title of ception 29c. License number 29d. Date signed (Month, Dev. Year) d eddress/of person who completed cause of deeth (Item 23e) (Type, Print) Mar BMDGE, MO. 213) 31. Dete filed (Month, Day, Year State JAN 1 2000 Registrar

DHMH 16 Rsv 6/95



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** 2000 Bruce January 6:50PM Sparkman /Medical 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 11528 Renner Rd. Frederick Keymar If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Months 1**X** M 2□ F 85 Yrs. 400-09-3195 May 16, 1914 Kentucky Director Usuel Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Med cal Examinat must be notified at once. 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yea 2000 No Maryland Frederick Keymar Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11528 Renner Rd. 21757 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed Decedent's Usuel Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) construction iron worker 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) John D. Sparkman Isabelle Frazier 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) Keymar, MD 21757 Hazel B. Sparkman/ wife 11528 Renner Rd. 20b. Pleca of Disposition (Neme of cemetery, cremetory or other pleca) 20c. Location - City or Town, State 20a. Method of Disposition Dete 1 Burial 2 Cremetion 3 Removel from State Mt. Tabor Cemetery 1/7/00 Rocky Ridge, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Fecility Hartzler Funeral Home 21. Signature of Fundual Servica Licansee dr 404 S. Main St. Woodsboro, MD 21798 23a. Part1. Effer the disease, or complications that cause 12 deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each into Approximate Interval Between Onset end Death **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical **Examiner** Examiner 190403 physician and s the burial-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last Due to (or as a consequenca 61): Division of Vital Records, P.O. Box 68760, death certificate be Physician/Medical Due to (or es e consequenca of): SB 950 jo ed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yaa 2 No 3 Probably 4 Unknown signed b by 24e. Wes an eutopsy performed? 24b. Were autopsy findings aveilable prior to Completed completion of cause of death? page 2 s 990 2/1NO 1 Yes 1 ☐ Yes 2 ☐ No certificate or Attanding Physician: 25. Was case referred to medical axaminer? 26. Piece of Deeth (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 8 □ Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 28e. Date of Injury (Month, Dey Year) 1 Natural 5 Pending after death. Director: Aft 1 Yes 2 No 2 Accident investigation 6 Could not be 3 Sulcide 28e. Place of Injury - At home, farm, street, fectory, offica building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) filled in by 4 Homicide 24 hours Funeral 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and placa, and due to the cause(s) and menner as stated.
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier edical To the Hosp within 24 hou To the Fune completely fi (Check only one) 29d. Date signed (Month, Dey, Year) 29b. Signeture end title of cartifier 29c. License number 00 30. Neme and eddress of person who completed cause of deeth (Item 23a) (Type, Print) Frederick mo 21701 lower effree 4 31. Date filed (Month, Dev. Year) 32. Registrar's Signeture State JAN 1 Registrar

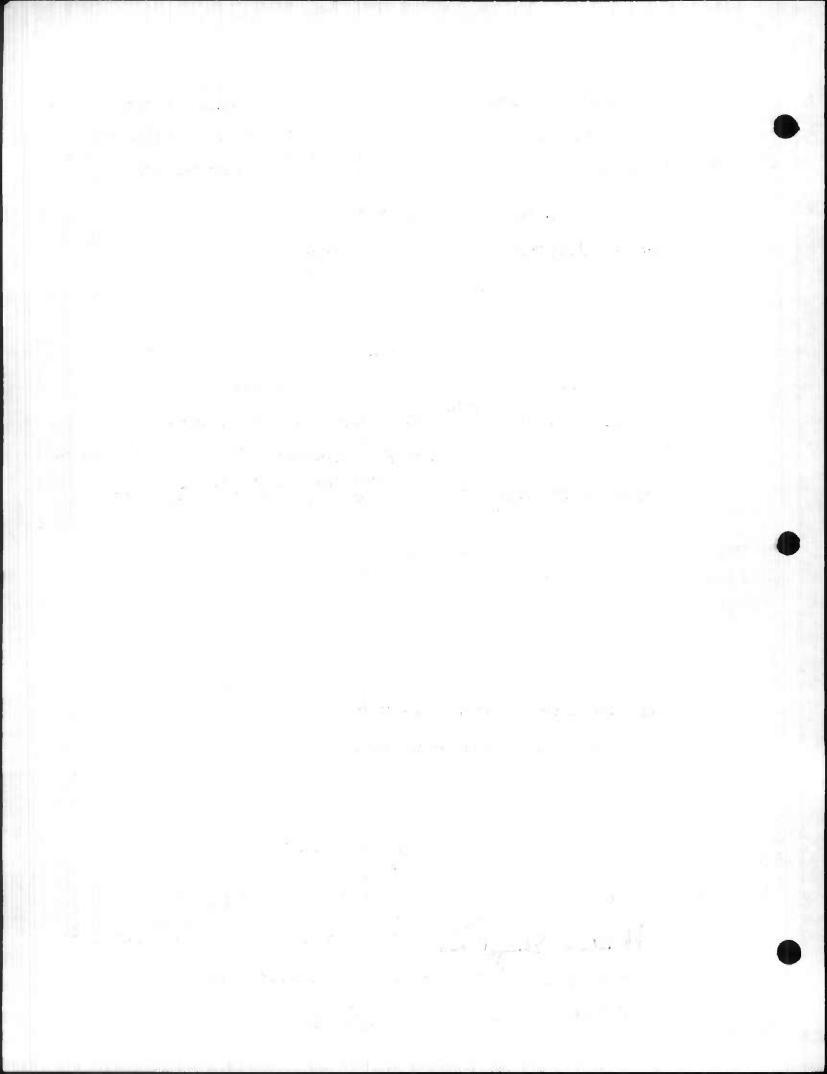


State of Maryland / Department of Health and Mental Hygiene 00 02303

| 10e. Street and Number 28424 Clarks 11. Marital Status 1 Never Married 2 Nover 15. Decec (Specify only hig Elementary/Secondary (0-12) 8 | n P. Shytl tion, give street and numb ospital 6. Sex TM M 2 F nty ontgomery ourg Road 12. Was Deced Armed Forc 1 Yes 2 1 Yes, Give Year or Dat tent's Education thest grade completed) 2) Collega (1-4 Shytle onship (Type, Print) (Da | Age (In yrs. last 87 10c. City, To lent Ever in U,S. less? No es: | own or Location Damascus 10f. Zip Co 13. Was Decedent If Yes, specify 1 Ves 2 | de 20872 of Hispanic Origin? (Scuban, Mexican, Puert No Specify: | 2. Date of Death January Location of Death Spring 8. Dete of Birth Month Dey March 10 pecify Yes or No- o Rican, etc.) | Bay 8, 20 4c. County Monto Monto (6, 1912) | 9. Birthy 2. Pour Court What Court A. White, White, | olace (State or Foreintry) C 10d. Inside City Lim 1 Yes 2 X ntry? can Indian, etc. |
|--|---|---|--|--|--|---|--|---|
| Holy Cross Ho 5. Sociel Security Number 241-09-8759 Usual Rasidance of Decedent 10a. State 10b. Cou MD Mk 10e. Street and Number 28424 Clarks 11. Marital Status 11. Never Married 2 Marital Status 11. Never Married 2 Marital Status 12. Never Married 2 Marital Status 13. Widowed 4 Movord (Specify only higher Specify only | ospital 6. Sex 7 M 2 F 7 M 2 M 2 F 7 M 2 M 2 F 7 M 2 M 2 M 2 M 2 M 8 M 2 M 2 M 8 M 2 M 8 M 2 M 8 M 2 M 2 M 8 M 2 M 2 M 8 M 2 M 2 M 8 M 2 M 2 M 8 M 2 M 2 M 8 M 2 M 2 M 8 M 2 M 2 M 8 M 2 M 2 M 8 M 2 M 2 M 8 M 2 M 2 M 8 M 2 M 2 M 8 M 2 M 2 M 8 M 2 M 2 M 8 M 2 M 2 M 8 M 2 M 2 M 8 M 2 M 2 M 8 M 2 M 2 M 8 M 2 M 2 M 8 M 2 M 2 M 8 M 2 M 8 M 2 M 8 M 2 M 2 M 8 M 2 M 2 M 8 M 2 M 8 M 2 M 2 M 8 M 2 M 8 M 2 | Age (In yrs. last 87 10c. City, To lent Ever in U,S. less) | Months Diverse Months Diverse Months Damascus 10f. Zip Code Mark Mark Mark Mark Mark Mark Mark Mark | Silver eer If Under 24 Hrs. ays Hours Min. de 20872 of Hispanic Origin? (Scuban, Mexican, Puert No. Specify: coupation one during most of worthired) | Spring 8. Dete of Birth Month, Det March 10 pecify Yes or No- o Rican, etc.) | Monto 6, 1912 Og. Citizen of V USA 14. Race Blace Specify | 9. Birthy 2. Pour Court What Court A. White, White, | olace (State or Foreintry) C 10d. Inside City Lim 1 Yes 2 X ntry? can Indian, etc. |
| Usual Rasidance of Decedent 10a. State 10b. Cou MD Mk 10e. Street and Number 28424 Clarks 11. Marital Status 1 Never Married 2 Noivord 15. Decedity only hig Eiementary/Secondary (0-12) 8 17. Father's Name (First, Middle Lum 19a. Informant's Name/Relation Mrs. Linda Suc 20a. Method of Disposition 18 Buriel 2 Crematic 4 Donation 5 Other | nty ontgomery Durg Road 12. Was Deced Armed Forc 1 Yes, Give yed Yes, Give yed Collega (1-4) 2) Collega (1-4) Shytle onship (Type, Print) (Da | 10c. City, To | Months Diverse Months Diverse Months Damascus 10f. Zip Code Mark Mark Mark Mark Mark Mark Mark Mark | de 20872 of Hispanic Origin? (Scuban, Mexican, Puert No Specify: | pecify Yes or No- o Rican, etc.) | Og. Citizen of V USA 14. Race Blace Specify | What Could A A se - Americal Country White, White, White, | ntry) NC 10d. Inside City Lim 1 □ Yes 2 ▼ ntry? can Indian, etc. |
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| Lum S 19a. Informant's Name/Relation Mrs. Linda Suc 20a. Method of Disposition XD Buriel 2 Crematic 4 Donation 5 Other | Shytle onship (Type, Print) (Da | hi si | | | | Securi | ity | |
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| 20a. Method of Disposition Buriel 2 Crematic 4 Donation 5 Other | e Patterson | ugnter) | | reet end Number or Ru | ral Route Number, | City or Town, | | |
| 21. Signature of Funerei Servi | | ceme | 28424 Clarl of Disposition (Neme of tery, crametory or other oringfield (| plece) | г | 20c. Location - | City or To | |
| . 1 | ce Licensee | let | HAIGHT F | UNERAL HOM | E & CHAPI | EL (Box | 195 |) |
| Immediate Cause (Final disease or condition resulting in death) | ist only one cause on eac | Pneumo | nia a consequence of): | | | | 1 | Interval Batweer Onset end Deat Week |
| Sequantially list conditions, if any, leading to immadiata cause. Enter Undarlying Cause (Disease or injury that initiated avants resulting in death) Last | b. c. | | | | | | | |
| | | | | a givan in Part I. | | | | |
| Dementia, Dia | abetes Melli | tus, Sen | ile Inaniti | .on | perform | ned? | ev | ere autopsy findin vailable prior to empletion of cause death? |
| | cel | | | 26. Piace of Dea | | | 1 [| Yes 2 No |
| exeminer? 1 ☐ Yas 2 ☐ XNo | Hospital: 1 Xing | patiant 2 ER/ | Outpatiant 3□ DOA | Other: | | | er (Specil | (y) |
| 2 Accident inva 3 Sulcide 6 Cou | stigation id not be graphed 28e. Piace of | f Injury - At home, | М | 1 ☐ Yes 2 ☐ No | 28f. Location (Str. | reet and Numb | | al Route Number, |
| 29a. Certifier 17 Certifier (Check only one) 2 Medic | place, and due to the causa(s) and manner as stated | | | tated. the causa(s) | | | | |
| | | 6g | | | 29 | | | |
| 2 | any, leading to immadiate ause. Enter Undarlying ause (Disease or Injury hat initiated avants esulting in death) Last and It. Other eignificant cond Atrial Fibril Dementia, Dia 5. Was case referred to mediexeminer? 1 | any, leading to immadiate ause. Enter Undarlying lause (Disease or injury nat initiated avants esulting in death) Last art It. Other eignificant conditions contributing to death Atrial Fibrillation, Str. Dementia, Diabetes Melli 5. Was case referred to medical exeminer? 1 Yas 2 Wo 7. Manner of Death 1 Natural 5 Pending invastigation 28a. Date of (Month, 21a) 28a. Date of (Month, 21a) 28a. Date of (Month, 21a) 28a. Place of building 28a. Certifier (Check only 2 Medical Examiner: On the bas and manna 28b. Signature and title of certifier 9a. Certifier (Check only 2 Medical Examiner: On the bas and manna 28b. Signature and title of certifier 9b. Signature and title of certifier 9c. Nama and address of person who completed cause Martin C. Sharbee, MD | any, leading to immadiate ause. Enter Undarlying ause. Enter Undarlying ause. Chisease or injury nat initiated avants esulting in death) Last Due to (or as a d | any, leading to immadiate ause. Enter Undarking ause. Enter Undarking ause. Enter Undarking ause. Chisaase or injury hat initiated avants esulting in death) Last Due to (or as a consequence of): d. Due to (or as a consequence of): d. Atrial Fibrillation, Stroke, Multi—Infarct Dementia, Diabetes Mellitus, Senile Inaniti Dementia, Diabetes Mellitus, Senile Inaniti Dementia, Diabetes Mellitus, Senile Injury 1 Yas 2 Ylo | and the description of the properties of the pro | any, leading to immadiate ause. Enter Undarlying ause (Disease or Injury ause) (Month, Dey Year) 92. Certifier (Check only one datarminad) (Check only one) (Check | any, leading to immadiate ause. Enter Undarlying auses. Enter Undarlying auses. Enter Undarlying auses. Enter Undarlying auses Chief Undarlying Causa givan in Part I. Atrial Fibrillation, Stroke, Multi-Infarct 1 Yes 2 No 24a. Was an autopsy performed? 1 Yes 2 No 25b. Was case referred to medical exeminer? 1 Yes 2 No 26c. Place of Death (Check only one) 27c. Manner of Death 1 Xinpatiant 2 ER/Outpatiant 3 DOA Other: 4 Nursing Homa 5 Residance 8 Other 28c. Injury at 28d. Describe how injury occur (Morith, Dey Year) 1 Yes 2 No 28c. Place of Injury 28c. Place of Injury 28c. Injury | art it. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. Atrial Fibrillation, Stroke, Multi-Infarct Dementia, Diabetes Mellitus, Senile Inanition 24a. Was an autopsy performed? Dementia, Diabetes Mellitus, Senile Inanition 24a. Was an autopsy performed? 25b. Did tobacco use contribute to the cause of the performed? 24a. Was an autopsy performed? 24b. Was an autopsy performed? 25c. Place of Death (Check only ona) Hospital: 12 Inpatiant 2 ER/Outpatiant 3 DOA Other: 4 Nursing Homa 5 Residence 8 Other (Specific Month), Dely Year) 25d. Describe how injury occurred injury Month 1 Yes 2 No 1 |

Registrar

JAN 1 0 2000 32. Registrar's Signature G. Spark



State of Maryland / Department of Health and Mental Hygiene

02394

| | | | | | | Ce | rtificate | of | Death | | F | leg. No. | | 06 | 0 2 4 |
|---|--|--|-------------------|--|--------------------------|--|--------------------------------|----------------|--------------------------------------|-------------------|--|-----------------|-------------------------|---------------------------------|--------------------------|
| | | 1. Decedent's Name (First, Midd | lle, Last | 1) | | 11 113 | | | | | 2. Date of Dea Month | th Day | Year | 3. Time | of Death |
| Physic | | Bertha | | Almed | la | Swar | nk | | | | January | | | 203 | 35 P |
| /Med Exam | | 4a Fecility Name (If not institution | n, give | street and num | ber) | | | | 4b. City, Tow | n, or Lo | cation of Deeth | 4c. County | | | |
| | | Laurelwood C | are | Center | | | | | Elkt | on | | Ceci | 1 | | |
| Funera Directo | | 5. Social Security Number 208-14-8016 | 6. Se | M 2XF | 7. Age (In yrs. I 80 | ast birthdey, Yrs. | If Under 1 Months | Yeer | Hours | Min. | 8. Dete of Birth (Month, Dey May 31, | | 9. Birthy Cou Per | place (Stei intry) insylv | e or Foreig vania |
| 2 | -11 | Usual Residence of Decedent | | ` | 1.0.00 | | | | | | | | | | |
| anylar show | | 10e. State 10b. Count | | | 10c. City | , Town or L | | rel. | 4 | | | | | | City Limits es 2 ☐ No |
| M o M | cto | Maryland St. | mary | /S | | Char. | Lotte 1 | | | | | | | | 65 2 140 |
| th with the 23s or 2 | ai Director | P.O. Box 51, | Rout | te 5 | | | 10f. Zip 0 | 622 | | | | United | | | |
| 5-0020 72 hours after death with the Manyland natural; or items 23a or 28a-f show deal Examiner must be notified at | by Funeral | 11. Marital Status 12. Wes Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 Yes 2 No If Yes, Give 3 Widowed 4 Provoced 1 Yes or Dates: | | | | | | | dispanto Original, Mexican, Specify: | n? (Spi Puerto | ecity Yes or No- Rican, etc.) | Ble | ce - Americk, White, | | • |
| 15-002 72 hours | Completed | 15. Decede | nt's Edu | ucation 16e. Decedent's Usual Occupati de completed) (Give kind of work done du | | | | | ation | of work | ina | 16b. Kind of B | usiness/in | ndustry | |
| | pie | Elementary/Secondary (0-12) | T | College (1- | 4or 5+) | (Give kind of work done during most life. DO NOT use retired) | | | | or work | ng . | | | | |
| Maryland 2121 d 2 should be filed within th and Mental Hyglena. 7 is marked other than traumatic event, the Me | Son | 10 | | Assistant Man. | | | | | | | Groce | - | | | |
| Maryland d 2 should be file th and Mental Hy 7 is marked othe traumatic event | Be (| 17. Father's Neme (First, Middle | , Last) | | | | | | 18. Mother's Nam | | | | | | |
| arylan should be nd Mental i marked of | 2 | Theodore You | nkei | r | | | | | Pea | rl | Irene S | pencer | | | |
| 2 sho and is me | | 19a. Informent's Neme/Relation | ship (T) | ype, Print) | | 19b. Mail | ng Address (| Street | end Number | or Run | al Route Numbe | r, City or Town | , Stete, Zij | ip Code) | |
| | | Arthur J. Swan | k, i | Jr./Son | | | | | ulevar | d, | North E | ast, Ma | ryla | nd 21 | .901 |
| Baltimore, I semit. Pages I and Department of Healt moortent: if Item 27 mortent or other 1900. | | 20a. Method of Disposition | 0 🗆 | | 0.0 | lace of Dispensery, cre | osition (Neme metory or oth | e of er ple | ce) | | Date | 20c. Location | · City or T | own, Stete | |
| Page ent mt: if | permit. Pages 1 an Department of Hael Important: if itsm 2 any injury or other ance. | 1X Burial 2 ☐ Cremetion 4 ☐ Donation 5 ☐ Other (| | | Nor | th Eas | t Meth | nod | ist Ce | m | 1/20/00 | North | East | t, Ma | rylan |
| mit. | | 21. Signeture of Funeral Service | Licens | 800 | | 2 | 2. Name end | Addre | ss of Facility | 31270 | rals, P | 7 | | | |
| m ages | | 1 | 0 | 1. | | | | | | | , Elkto | | , land | 2193 |)] |
| THE REAL PROPERTY. | | 23e. Part 1. Enter the disease, of | r comp | lications that ca | used the death | | | | | | | | Tana | Approxin | nate |
| Physician | | shock, or heart failure. Lis | t only o | ne cause on ea | ich line. | | | | | | | | i | Onset a | Between nd Death |
| */Medica | _ | Immediate Cause (Final | | - | - | , | 2/ | | | | | | | | |
| Examine | | disease or condition resulting in death) | | a | ntracr | ania | H | en | orrha | 2e | ilent | | | 2 Days | |
| .0. | ē | | | , | Due to (or | as a conse | quence or): | - | | 1 - | -0. t | | 1 | | |
| nsit | Examiner | | | b | | | | Ch | ar / | 4cc | (Dew ! | | i | 2 00 | 145 |
| y vacu | X | Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury | | | Due to (or | as a conse | quence or): | | | | | | i | | |
| . Box 68760, death certificate be axecuted e attending physician and of or use as the bunal-transit | | Cause (Disease or injury that initieted events | < | c | | CFC -=1 =217 | | | | | | | | | |
| r 687 | edicai | resulting in death) Last | | | Due to (or | es e conse | quence ot): | | | | | | | | |
| Centif | 5 | | L | d | | | | | | | | | | | |
| Box eath cert attendin | ia | | | | | | | | | | | | | | |
| IS, P.O. I res that the designed by the a | Completed by Physician/ | Part II. Other algnificant condit | ons co | ntributing to dea | ath but not resu | ilting in the i | inderlying ce | use gi | ven in Pert I. | | | obacco use co | | | , |
| P.O hai tha ed by the detache | 문 | Ovarian Care | ino | ma | | | | | | | 101 | res 2□No | 3 Pro | obably 4 | Unknow |
| Records, P.O. he law requires that that a hear been signed by the age 2 should be detached. | d b | Ovarian Care Acute Renal | | | | | | | | | 24a Was | an autopsy | 24h. V | Vere autop | sy findings |
| cord v require been si | etec | Acute Renal | F | ailure | | | | | | | | med? | a c | vailable pri ompletion | or to |
| I Rec | npi | | | | | | | | | | | , | of | f death? | |
| - F & d | S | | | | | | | | | | 1 🗆 Y | es 2 No | 1 | ☐ Yes 2 | ≥□ No |
| of Vital Re Physician: The li rihls certificate he aral director, page | Be | 25. Was cese referred to medic examiner? | | | | | | | - | of Deat | h (Check only o | ne) | | | |
| of V | 2 | 1□Yes 2☑No | | | | ER/Outpetie | nt 3 DOA | 1 | | - | me 5 Resid | | | lfy) | |
| C & 55 | Certification: | 27. Manner of Death 1 Natural 5 Pend 2 Accident inves | ing tigation | 28a. Dete o (Monti | f Injury n, Dey Year) | 28b. Time of Injury | of 28 | c. Inju Wo | ryat rk? ∣Yes 2 □ N | | 28d. Describe h | ow injury occu | red | | |
| isi then deal deal ctor: y the | S | 3 Suicide 6 Could | not be | 28e. Place | of Injury - At ho | me, farm, st | reet, factory. | office | | -+ | 28f. Location (5 | Street and Num | ber or Ru | ral Route N | lumber, |
| Or A after Direction by | erti | 4 ☐ Homicide deter | nined | | g, etc. (Specify | | | | | | City or Tou | m, State) | | | |
| Division or To the Hospital or Attanding Ph within 24 hours after death. To the Funeral Director: After th completally filled in by the funeral | edicai C | 29a. Certifier 1 ☐ Certify (Check only 2 ☐ Medica | ng Phy i Exami | iner: On the ba | sis of examinet | wledge, deal | th occurred a | t the ti | me, date and opinion, death | place, | and due to the cred et the time, | cause(s) and m | anner es | stated. to the caus | se(s) |
| the hin 2 the Inplet | Med | One) | | and mann | er stated. | | 000 | Lines | ea number | | | 29d Date size | ad /Adapth | Day Von | r) |
| S Vit | - | 29b. Signature end title of certific | | AAT | | | | | se number | 7 | | 29d. Date sign | | | |
| | | Monte Ma | noi | is, MIL | | | | D- | 4478. | 3 | | Janua | . 7 | 11,4 | 000 |
| 5 | | 30. Name and address of person Monte Ma | | | of death (Item | 23a) (Type | Print) | ish | STOR | et | , EL | KTON, | MO | 2/9 | 21 |
| C | tate | 31. Date tiled (Month, Dey, Yea |) | | gistrar's Signa | ture | | 1 | | | 1 | | | | |
| Regis | | JAN 1 8 200 | 0 | Sene | me 1 | 9. | have. | / | | | | | | | |

Registrar

A DELL SAFE FELL 15 1 1 1 1 1 1 1 1 1 ng promise after continue 3 H. M. Server NAME AND PARTY OF THE PARTY OF THE RESERVE OF THE R A SHALL SEE THE SELECTION OF THE SECTION OF THE SEC

State of Maryland / Department of Health and Mental Hygiene 00 02395

Certificate of Death

| | | Deall | 1109.110 | | | | | | | | | | |
|---|--|--|--|--------------------------------|--|---|--|---|---|--|---------------------------------|---|--|
| | 1. Decedent's Name (First, Middle, Last) Physician Shirley Soule Smith | | | | | | | | 2. Date of Dea Month January | Day | Year 000 | 3. Time of Death 5:30 PM | |
| /Medical Examiner | 61 Carilla Nama (Manakarakaria akanakaria akanakaria) | | | | | | 4b. City, To | own, or L | ocation of Death | 7 | | | |
| Examine | | 140 Monticello Ave. | | | | | | Annapolis | | | Anne Arundel | | |
| | | 5. Social Security Number 6. Sex 7. Age (In yrs. last | | | | | | | | h | | | |
| Funeral Director | 029-22-9 | | 1□M 2X F | | | Yrs. Months Day | | Min. | May 18 | 8, 1901 N | | thplaca (State or Foreign ountry) Aass. | |
| Director | Usual Residence of Decedent | | | | | | nay 20, 2001 Mass. | | | | | | |
| 72 hours after death with the Maryland natural; or Nems 23a or 28=7 show see Examine runt be motified at each of Funeral Director | 10a. State | 10b. County | 10c. City, Town or Location | | | | | | | | 10d. Inside City Limits | | |
| | MD. Anne Arundel Annapolis | | | | | | | | 1∑ Yes 2 No | | | | |
| 2 2 2 | 10e. Street and Number 10f. Zip Code | | | | | | | | 10g. Citizen of What Country? | | | | |
| vith the Ma | 100. Street and Number | | | | | | | | | | | | |
| 4 23 E | | | | | | | 1401 | | | USA | | | |
| r home 234 | 11. Meritei Stetus 12. Wes Decedent Ever in U, Armed Forces? | | | | U,S. 13. | J.S. 13. Wes Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto | | | | - 14. Rad Bie | ce - American ck, White, etc | | |
| of a m | | 1 Tes | 1 ☐ Yes 2 No If Yes, Give 1 ☐ Yes 2 X | | | | | 75-17-17 | Specify: | | | | |
| hy | 3 Widowed 4 Divorced Year or Detes: | | | | The state of the s | | | | White | | | | |
| ed within 72 hours att ygiene. her then "natural", or it, tre Medical Exact | 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of work | | | | | | | | ina | 16b. Kind of B | usiness/Indus | stry | |
| within i | Elementery/Sec | | College (1-4or 5+) | | life. | DO NOT use reti | red) | | w.y | | | | |
| d within | 5 | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | 4 | (, , , , , , , | Ex | ecutive | Secretary | | | Profes | ssiona | 1 Assoc. | |
| ETES a | | (First, Middle, Las | t) | | | | | 18. Mother's Neme (First, Midd | | le, Maiden Sumame) | | | |
| | Usamus Do | materia Consta | . L | | | | Florence Soule | | e Soule | | | | |
| | | | | | | | | | | or City or Tour | State 7in C | ode) | |
| U 40 | | | | | | | Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) | | | | | 506) | |
| Health Ham 27 other tr | | | ly Ler/II | | | 205 Providence Rd. | | | Annapolis, MD 21401 Dete 20c. Location - City or Town, Stete | | | 54.4 | |
| t of Heart If Heart or othe | 20a. Method of Di | | □Removei Iro | | cemetery, crei | metory or other p | lece) | | Dete | 20c. Location | - City or Town | 1, Stete | |
| 4 5 5 5 | | 1 Buriel 2 Cremetion 3 Removes from State 4 Donetion 5 Other (Specify) Metropolitan Crematory | | | | | | | -10-00 Alexandria, VA. | | | | |
| Departmen Important: any injury | 21. Signeture of F | unerel Service Lica | inst | | 22 | 2. Neme and Add | Iress of Fecil | | | | | | |
| Department of the contract of | 1 P | John M. Taylor Funeral Home, Inc. | | | | | | | | | | | |
| | - | 147 Duke of Gloucester St. Annapolis, MD 21401 | | | | | | | | | | | |
| | | | | | | | | | | | | ntervel Between | |
| hysician | | | | | | | | | | | 1, | riset end Death | |
| /Medical Examiner | Immediate Cause (Final disease or condition condition condition or condition | | | | | | | | ent | 1 week | | week | |
| | resulting in death) Due to (or as e consequence of): | | | | | | | | | MAN | | | |
| | Idmnitensin | | | | | | | | | VEAR | | | |
| in and hal-transit Examiner | Sequentially list o | onditions. | D | Due to | (as e consec | - | | | | | 1 | 6/1/1/2 | |
| in ar | | immediete dertying | | | , | | | | | | | | |
| nding physician and use as the burial-transit | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (* as a consequence of): Due to (or as a consequence of): | | | | | | | | | | | | |
| Et D | resulting in deeth) Lest | | | | | | | | | | | | |
| ding physician and use as the burisl-tran | d | | | | | | | | | | | | |
| | | | | | | | | | | | | 100 | |
| y the atter | Pert II. Other significant conditions contributing to death but not rest | | | | esulting in the underlying cause given in Part I. | | | I. | 23b. Dld 1 | 23b. Did tobacco use contribute to the cause of death? | | | |
| Ph etac | | | | | | | | | 10 | Yen 2 No | 3 Probal | bly 4 Unknow | |
| been signed by the atter should be detached for a | | | | | | | | | | , | | | |
| S P | | | | | | | | | | 24a. Wes en autopsy performed? 24b. Were autopsy linding available prior to completion of cause of death? | | | |
| ate has been si page 2 should Completed | | | | | | | | peno | | | | | |
| ge 2 | | | | | | | | | | | | | |
| Com | | 1 Yes 2 1 Yes 2 | | | | | | | | | res 2LINo | | |
| is certificate director, pag To Be Co | 25. Wes case refe axaminer? | erred to medical | 26. Place of Deeth (Check only one) | | | | | | | | | | |
| O | 1 □ Yes 22 | No 1th 5 □ Pendina | Hospitei: | Inpatient 2 | ☐ ER/Outpatier | nt 3 DOA | | | ome 5 Resid | esidence 6 Other (Specify) | | | |
| her th | | | 28a. Det | e of Injury onth, Day Year) | 28b. Time of | f 28c. In | | | 28d. Describe how injury occurred | | | | |
| r deeth. ector: Afte by the fune iffication | 2 Accident | investigetic | | | | | | Yes 2 No | | | | | |
| as after deeth. al Director: After t led in by the funera Certification: | 3 ☐ Suicide 6 ☐ Could not be determined 28e. Plece of Injury - At home, Ierm, street, lectory, office | | | | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| ata di para | 4 Homicide | | building, etc. (Specify) City or Town, State) | | | | | | | | | | |
| within 24 hours To the Funeral completely filled | | Cartifying D | hvalcian: To # | he best of my k | nowledge deet | occurred at the | time date e | nd niace | and due to the | cause(s) and m | anner as etel | ed. | |
| Fun Fun | (Check only 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the | | | | | | | | | | | ne cause(s) | |
| within 24 hours after deeth. To the Funeral Director: After th completely filled in by the funeral Medical Certification: | | | | | | | | | | | | Vest | |
| × 000 | 250. Signeture an | 29b. Signeture and title of certifier 29c. License number | | | | | | | 29d. Date signed (Month, Day, Year) | | | | |
| | 1 TL Sust Zdw. MD 130701 | | | | | | | 1/1/00 | | | | | |
| | 30. Neme and add | dress of person who | completed ca | use of death (It | em 23a) (Type, | Print) | | | | 11 | | | |
| | | t Eden. M | | | gely Av | | ite 12 | O A1 | nnapolis | g MD | 21401 | | |
| State | 31. Dete liled (Mo | | | Registrar's Sig | | 501 | rre | - 111 | aporta | ,, | = TUL | | |
| State | | IAN 1 1 20 | ากก | Street | 1 19 | 100 | 1 | | | | | | |

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State of Maryland / Department of Health and Mental Hygiene U Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Dafa of Death 3. Tima of Death Day Month Yes **Physician** Janice W. Sherwood January 4 2000 6:00 PM /Medical 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Manresa on the Severn Annapolis Anne Arundel 5. Sociel Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) July 15, 1914 Birthplace (State or Foreign Country) Funeral Deys Hours Months Director 203-24-9429 Pennsylvania Usuei Residence of Decedant the Maryland 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Itema 23a or 28a-f show the Madical Examples must be nothed at 1 Yes 2 No Director Anne Arundel Annapolis 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 85 Manresa Drive 21401 USA Funeral deeth 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 12. Wes Decedent Evar in U,S. Armed Forces? 14. Race - American Indian, 11 Merital Status Black, Whita, etc. 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give 1Ĭ Nevar Married 2 ☐ Merried Baltimore, Maryland 21215-0020 1 Yes 2√ No Specify: Specify: þ 3 Widowed 4 Divorced Yaar or Datas White Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mentel Hygiens. Important: if then 27 is marked other than "r any Injury or other traumatic avants. College (1-4or 5+) 5+ Elementary/Secondery (0-12) Assistant Director Library 17. Fether's Neme (First Middle Last. 18 Mother's Name (First Middle Maiden Sumame) Be Ray P. Sherwood Dessie Patterson 19b. Mailing Addrass (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) Dr. Arthur W. Patterson/cousin 219 Riverside Dr. Annapolis, MD. 21401 20b. Place of Disposition (Name of cametery, cremetory or other place) 20e. Method of Disposition Data 20c. Location - City or Town, State 1 XBuriai 2 Cremetion 3 Removel from Stete Prospect Hill Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) 1-10-2000 York, PA. 22. Nama and Addrass of Fecility John M. Taylor Funeral Home, Inc. 21. Signeture of Funerel Service Licen 147 Duke of Gloucester St. Annapolis, MD. 21401 23a. Pert1. Enfar the disease, or complications that coused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. **Physician** /Medical Immediate Ceuse (Finel diseese or condition resulting in death) Examiner Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate ceuse. Enter Undarfying Cause (Disease or injury that initiated events rasulting in death) Last Due to (or as a consequence of) and physician as the buriel-Box 68760. Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown signed by Osteoporogis P 8 24b. Ware autopsy findings available prior to completion of cause of death? 24e. Wes en eutopsy performed? Completed Le pression peen hes 1 Yes 2 No 1 Yes 2 No certificate To the Hospital or Attanding Physician: within 24 hours after death.

To the Funeral Director: After this certific 25. Was case referred to medical axaminer?

1 Yas 2 No Be 26. Place of Deeth (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Hasidence 6 Other (Specify) Certification: To funeral 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Menner of Death 28b. Time of 28c. Injury at Work? 1 Maturel 5 Pending 1 Yes 2 No invastigation 2 Accident 6 Could not be datamined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Piece of Injury - At homa, ferm, sfreet, factory, office building, etc. (Specify) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, data and place, and due to the cause(s) end menner stated. edicai 29a. Certifiar (Check only one) 29b. Signaturu and 29d. Date signed (Month, Day, Year) 29c. License number 8529-MD 30. Nema and addrass of person who completed cause of death (Itam 23a) (Type, Print) Jon B. Lowe, M.D. 2009 Tidewater Colony Drive Annapolis, MD. 31. Date filed (Month, Day, Year) 32. Regisfrar's Signatura

State Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 10 2000 Irwin Maxwell Sparks January 3:30 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 203 Woods Drive Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs. 5. Social Security Number Birthpiace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) **Funeral** Months Days Hours 1□XM 2□ F 214-26-2604 68 Jan. 4, Director 1932 Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ahow t than "natural", or hems 23s or 28s-f show the Medical Examiner must be notified as 1 Yes 2 No Directo Maryland Anne Arundel Annapolis 10a. Street and Number 10f. Zio Code 10g. Citizen of What Country? deeth with 203 Woods Drive 21403 USA Funeral 11 Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Waa Decedent of Hispanic Origin? (Specify Yea or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baitimore, Maryland 21215-0020 1 Yes 2 No Specify: P 3 Widowed 4 Divorced White "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 7 Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled wit Department of Heelth and Mental Hygiena Important: If item 27 is marked other tha any injury or other traumatic event, that page. Draftsman Electric Utility Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 8 Ruth B. Kelley William A. Sparks 2 19a. Informant'a Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stephen J. Sparks / Son 2092 Lower Ct. Crofton, Md. 21114 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Stevensville Cemetery 01-14-00 Stevensville, Maryland 21. Signature of Funeral Service License 22. Name end Address of Facility John M. TAylor Funeral Home, Inc. 147 Duke of Gloucester Street Annapolis, Md. 21401 ou 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feiture. List only one cause on each line. Approximate Intervat Between Onset and Deeth **Physician** /Medical Immediate Cause (Final ems disease or condition resulting in death) Examiner Examiner physicien end the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events reaulting in death) Last Records, P.O. Box 68760. Physician/Medical Due to (or as a consequence of): 987 Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23h. Did tobacco use contribute to the cause of death? signed by to d be detach 1 Yas 2 No 3 Probably 4 Unknown p 24b. Were autopsy findings available prior to completion of cause of death? should I 24a. Wes an autopsy performed? Completed has 20 No certificate 1 ☐ Yas 2 ☐ No Division of Vitai To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 8 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) To Hospital: 1 | Inpatient 2 | EP/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□ Yes 2√ No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. tnjury at Work? 5 Pending investigation Natural 1 Tyes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of tnjury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide edical 29a. Certifie 繩 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Patiment Parkway Columbia, MD 21044

State Registrar

Jerusne

31. Date filed (Month, Day, Year)

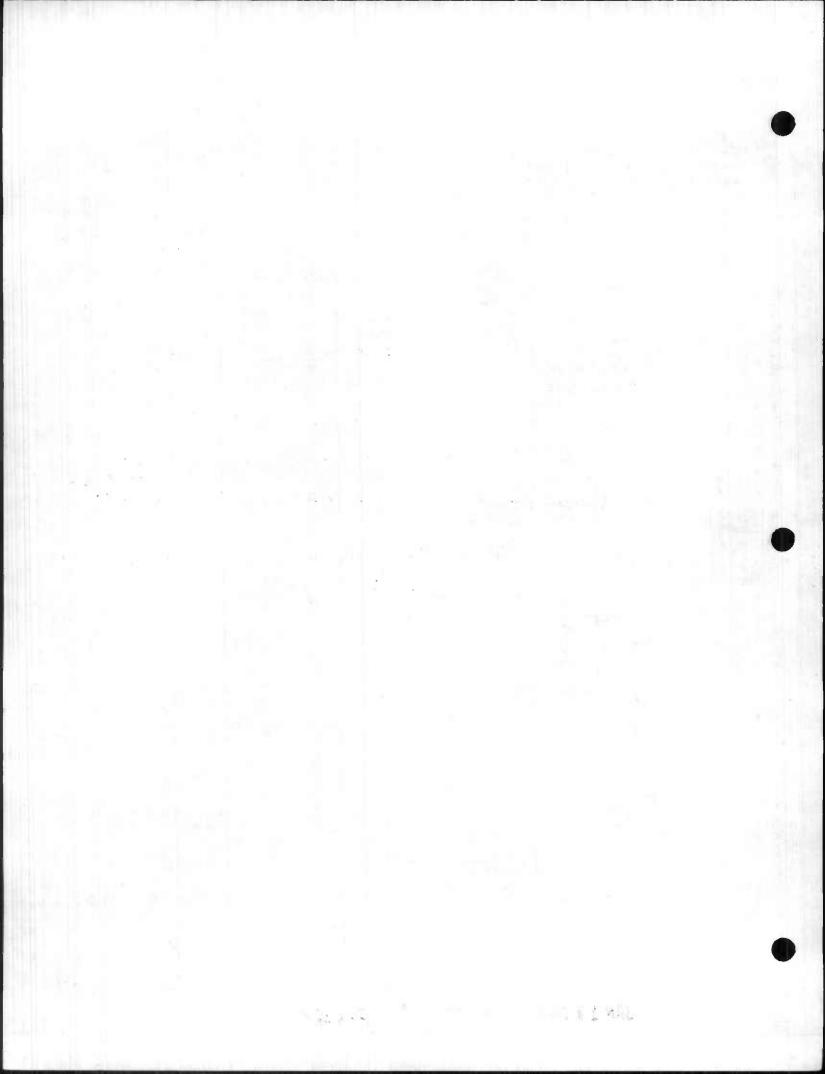
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32. Registrar'a Signature

HANTMAN, MO

JAN 1 3 2000



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene (Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician January 5, 2000 Margaret Virginia Schmidt 5:19 pm /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 227 Larch Place Stevensville Queen Anne's If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yea **Funeral** Days Hours Months 1□ M 2♥ F Yrs. 577-26-2491 79 Oct. 1, 1920 Maryland Director Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits rail, or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Maryland Oueen Anne's Stevensville 10e. Street and Number 10g, Citizen of What Country? 10f. Zip Code 211 Bay Drive U.S.A. 21666 Funeral death 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ₺ No If Yes, Give Year or Dates: 11. Meritel Stefus 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black White etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0020 'natural', or 1 ☐ Yes 2 No Specify: Specify: White þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72. Department of Health and Mental Hyglene. Important: if Item 27 is marked other than "nation any Injury or other traumatic event, the Medical page. Elementery/Secondery (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Be Julius Ferdinand Stommel Nellie Franklin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) Peggy A. Allen - Daughter 830 Sportsman Neck Road, Queenstown, Maryland 21658 20b. Place of Disposition (Name of cemetery, crematory or other placa) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Buriel 2 Cremetion 3 Removal from State Fort Lincoln Cemetery 01/10/00 Brentwood, Maryland 4 Donation 5 DOther (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility
Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel disease or condition resulting in death) Carcinoma of the Lung 3-4 Years Examiner Due to (or as a consequence of): Examiner physician and the buriel-transit the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequença of): Box 68760. Physician/Medical Due to (or es e consequence of): Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. 1 ♥ Yea 2 No 3 Probably 4 Unknown Cigarette Smoking signed b þ The law requires 24b. Were autopsy findings available prior to should should 24a. Was an autopsy performed? Completed completion of cause of death? page 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital Be 25. Was case referred to medical axaminer? 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 10 Other (Specify Daughter's Home To 1 Yes 2 No this 28a. Dete of Injury (Month, Dey Year) 27. Manner of Death 28d. Describe how injury occurred Certification: 28b. Time of 28c. Injury at Work? 1 Netural 2 Accident or Attending 5 Pending Investigation 1 ☐ Yes 2 ☐ No death. Director: A 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify) 24 hours after de Funeral Direct pletely filled in by 4 D Homicide Hospital 29a. Certifier t Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and menner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and menner stated. To the H within 24 To the F complete 29b. Signature and title of certific 29c. License number 29d. Dete signed (Month, Day, Year) - a 00 D37064

(20) State

Registrar

31. Date filed (Month, Day, Year)

JAN 1 4 2000

James Chamberlain, M.D.

32. Registrar's Signature

no and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 16 Rev 6/95

130 Love Point Road #107, Stevensville, MD 21666

141 3 × 2000

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month Year Oliver Preston Tyler January 10, 2000 11:10 PM 4a. Facility Name (If not Institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Dorchester General Hospital Cambridge Dorchester If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months 100 M 2□ F 214-07-8014 87 Vrs March 15,1912 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits YYYes 2 No Maryland Dorchester Cambridge 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 507 Robbins Street 21613 US 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 1 ☐ Yes ŽÍXNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes XX No Specify: White Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Wire Cloth Elementery/Secondary (0-12) College (1-4or 5+) Loom Operator Manufacturer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumame) Tyler Oliver Preston Willie Andrews 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 507 Robbins Street Cambridge, Maryland 21613 Margaret M. Tyler Wife 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Dorchester Memorial Park 1/13/2000 Cambridge, Maryland 22. Name and Address of Facility Thomas Funeral Home, P.A. 21. Signature Funerel Service Licenses 700 Locust Street Cambridge, Maryland 21613 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, should, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final Uremia 2 weeks disease or conditi-resulting in death) Due to (or es e consequenca of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequença of): Due to (or as a consequence of) Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown chronic renal insufficiency 24b. Were autopsy findings aveilable prior to completion of cause of deeth? 24a. Was an autopsy performed? hypertension 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Deeth (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1≱Inpatient 2□ER/Outpatient 3□ DOA

Physician /Medicai Examiner

permit. Pages 1 and 2 at Department of Health and Important: If hem 27 is n any injury or other traus once.

Physician

/Medical

Examiner

Funeral

Director

r 28a-f show

7 is marked other than "natural", or Itams 23s or traumatic event, the Medical Examinat must be n

d 2 should be tiled within 72 th and Mental Hygiene. 7 is marked other than "na al Hygiene.

Baltimore, Maryland 21215-0020

Director

Funeral

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Completed

physician and the buriel-transil 80 for use es ed by the al s been signed by t should be detach page 2 certificate has

P.O. Box 68760.

Division of Vital

Examiner Physician/Medical Be 0 Certification:

þ Completed

Medical

 Mospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this certifical lietely filled in by the funeral director, To the Hospi within 24 hou To the Funer completely fil

4 Homicide 29a. Certifier

27. Manner of Death

1 Netural

2 Accident

3 ☐ Suicide

5 Pending Investigation

6 Could not be determined

28a. Date of Injury (Month, Day Year)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of 28c. injury at Work?

1 Yes 2 No

28f. Location (Street and Number or Rurel Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and manner stated.

28d. Describe how Injury occurred

29b. Signeture and the opportune

29c. License number D050799

29d. Date signed (Month, Day, Year) January 11, 2000

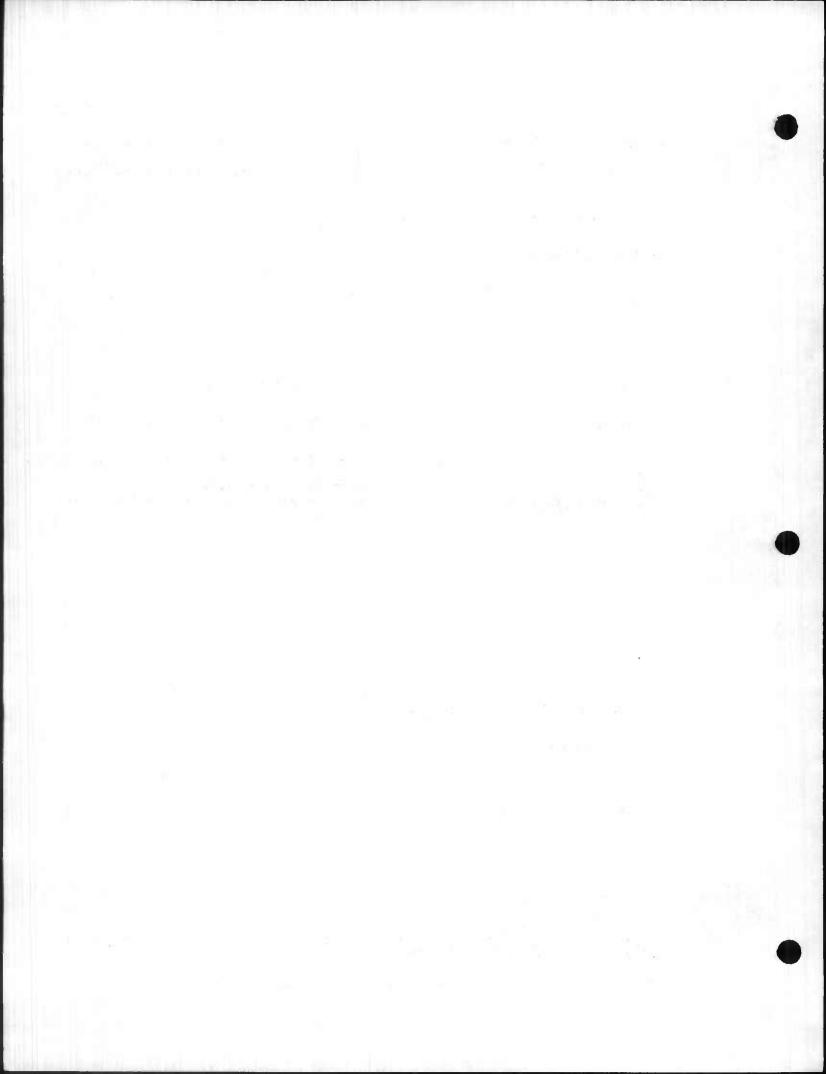
30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print)

Shirin Mohammad, MD 302 Collins Avenue Hurlock, Maryland 21643 31. Date filed (Month, Day, Year)

State Registrar

JAN 13 2000





Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death Month Dev Vear CHARLES BERKELEY TODD, JR. 12 2000 JAN 0324 4c. County of Death 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death TALBOT MEMORIAL HOSPITAL @ EASTON If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Min. 1√ M 2□ F Hours 219-26-5644 61 MAR.14,1938 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Federalsburg 1 ☐ Yas 2 No Dorchester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5256 Williamsburg Road 21632 United States 14. Race - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 1 DYes 2 No eserv If Yes, Give Year or Dates: 8 V no Black, Whita, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Construction Home Improvement 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Charles Berkeley Todd, Sr. Eva Mae Wright 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Intormant's Neme/Reletionship (Type, Print) 21632 Margaret A. Todd/Spouse 5256 Williamsburg Rd., Federalsburg, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stata 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Crest Cemetery 1/15 Federalsburg, MD Hill 4 ☐ Donation 5 ☐ Other (Specify) Framptom-Hawkins-Eskow Funeral Home, PA 21. Signeture of Funeral Service Licenses icha PO Box 43, Federalsburg, MD 21632 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tellure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting In death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as e consequence of): Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Ware autopsy findings available prior to completion of causa of death? 24a. Was an eutopsy performed? 1 ☐ Yes 1 □ Yes 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 27. Manner of Beath 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 1 Natural
2 Accident

Examiner Examiner physician and the burial-transit The law requires that the death certificate be executed Box 68760. Physician/Medical 88 080 P.O. Division of Vital Records, P Completed **page 2** certificate has To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director. Be OL Certification:

Physician

/Medical

Examiner

Funeral

Director

28a-1 show

b

Nerns 23a

Hygiens. other than "natural", or

permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygen Important; if hen 27 is marked other th any injury or other free

Physician

/Medical

Maryland 21215-0020

Baltimore,

Director

Funeral

þ

Completed

Be

MD

25. Was case referred to medical examiner? 1 Yes 2 No

5 Pending investigation

6 Could not be

28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

🖎 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and little of certifier

3 ☐ Suicide

29e, Certifie

4 Homicide

(Check only one)

29c. License number D005360Z 29d, Data signed (Month, Day, Year)

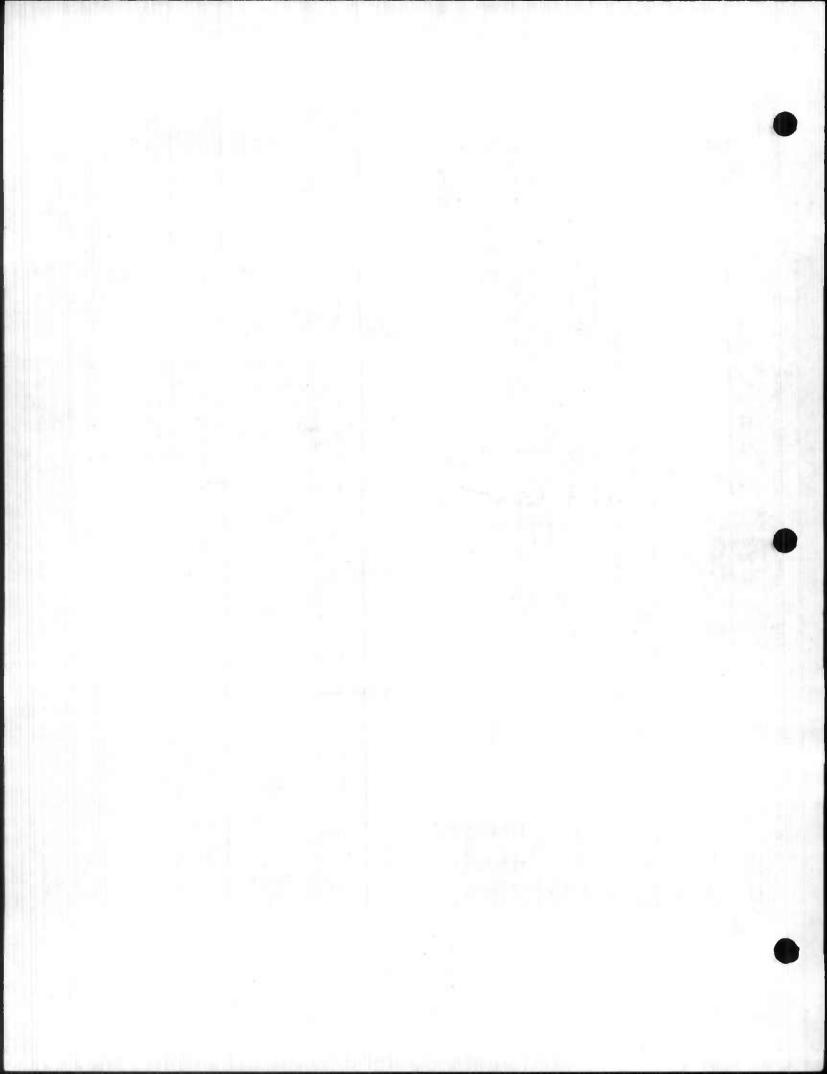
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD 606 Dutchman's Lane, Easton, MD 21601 Carolyn Helmly 31. Date filed (Month, Day, Year)

State Registra

edical

32. Registrar's Signature Beneva JAN 1 4 2000



Please Type or Print In Black Indelible Ink. Assure Ali Copies Are Legible.

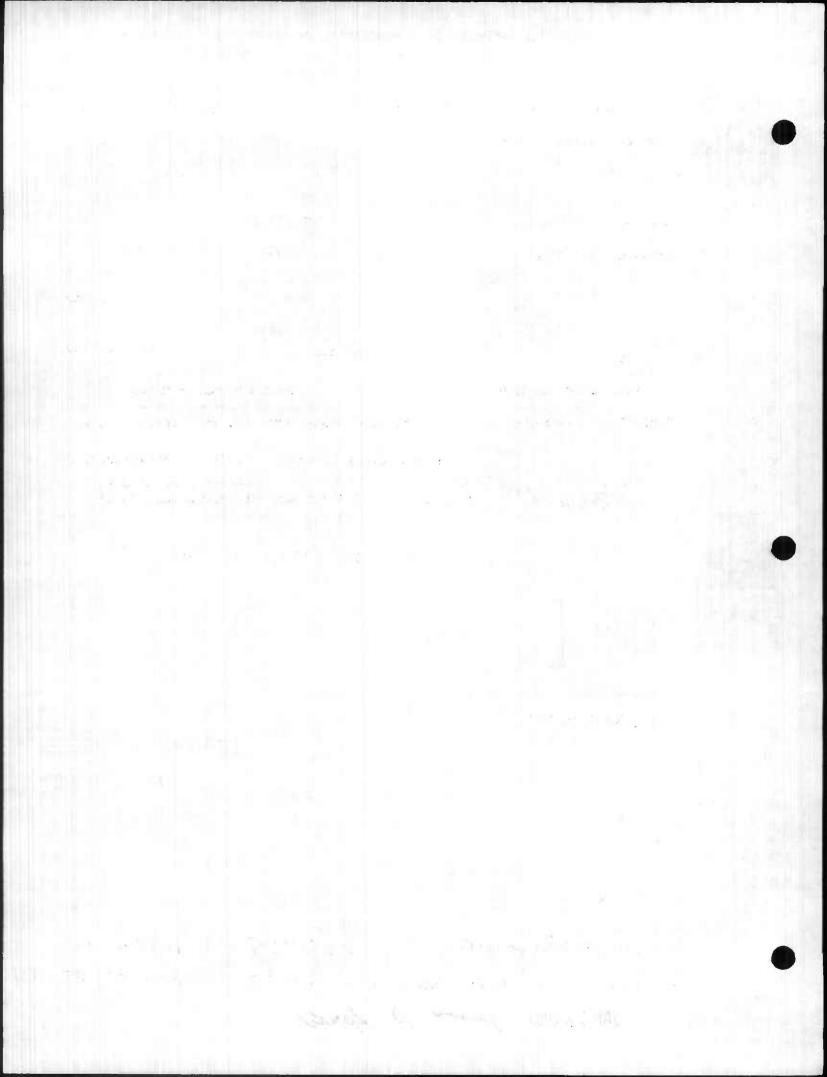
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Tima of Death Month Day **Physician** Marguerite Virginia Tiedemann 9:44 am Jan 16, 2000 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, giva street and number) Examiner Long View Nursing Home Manchester Carroll If Under 24 Hrs. If Under 1 Year 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1 M 2 XF 216-52-7773 Yrs Director 86 Apr 17,1913 Maryland Usual Residence of Decedent should be filed within 72 hours after death with the Maryland nd Mental Hygiene. marked other than "natural", or items 23s or 28s-f show 10a. Stata 10c. City, Town or Location 10d. Inside City Limits 10b. County r than "natural", or items 23s or 28s-f show the Modical Example; must be notified at 1 Yes 2 XNo Emmitsburg Maryland Frederick Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21727 USA Friends Creek Road Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, Biack, White, etc. 11 Marital Status 1 ☐ Yes 2 ☑ No if Yas, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: White Specify. by 3 Midowed 4 Divorcad Completed 15. Decedent's Education (Specify only highest grade completed) 18a. Decedent's Usuai Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) Meat Cutting Butcher permit. Pages 1 and 2 should be file Department of Health and Mental Hy, important: if item 27 is marked othe any injury or other traumatic event, phose. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Joseph Banner Tressler Carrie Virginia Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elsie Beall, daughter 554 Old Westminster Rd, Westminster, MD 21157 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State ₩ Burial 2 Cremation 3 Removal from State 1/19 Friends Creek Cemetery Emmitsburg, MD 4 Donation 5 Other (Specify) 22. Nama and Addrass of Facility M00723 Eline Funeral Home 934 South Main St, Hampstead, MD 21074 23a. Part1. Enter the diseasa, or complications that ceused the death. Do not enter the mode of dylng, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death **Physician** cell cancer of parotid Immediate Cause (Final disease or condition resulting in death) /Medical Sanamons Examiner Due to (or as a consequence of Physician/Medical Examiner The law requires that the death certificate be executed attending physician and for usa as the bunal-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequenca of): Division of Vital Records, P.O. Box 68760, that initiated events resulting in death) Last Due to (or as a consequence of) ed by the a Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23h. Did tohacco use contribute to the cause of death? 1 Yes 2 No 3 □ Probably 4 □ Unknown Dementia p should l 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to Completed completion of ceuse of death? certificate has b irector, page 2 s 2 No 1 ☐ Yas 2 ☐ No 25. Was case referred to medical examinar? Be 26. Piace of Death (Check only one) To Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Date of injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred Certification: Aftar 1 or Attanding 5 Panding investigation death. 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 6 after 4 Homicide 24 hours at Funeral Dietely filled Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier To the Hosp within 24 hos To the Fune completely fi (Check only one) 29b. Signature and title of certifian 29c. License number 29d. Date signed (Month, Day, Year) 0051705 9100 30. Name and address of person who completed cause of death (item 23a) (Type, Print) malcolm DR, westminster, mo21157 PANSURIYA, MO

State Registrar

31. Date filed (Month, Day, Year) JAN 1 8 2000

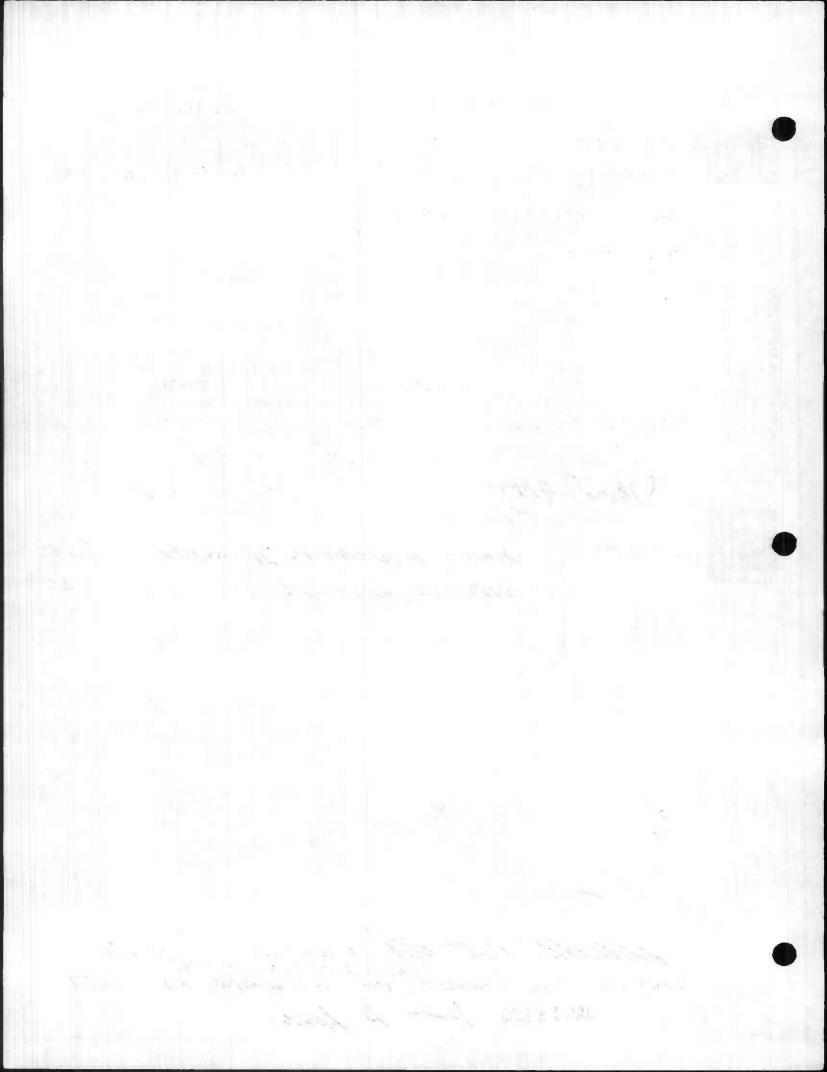
32. Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 2402

| والمنازلة | | | | | Certific | cate of | Death | | Reg. No. | 0 02402 | | | |
|---|---|---|---|--|---|---|--|--|--|--|--|--|--|
| hysician | 1. Decedent's Name | | | | | | | 2. Dete of D Month | eath Dey | 3. Time of Dea | | | |
| ledical | | CZ | AROL DIA | NE TR | ACEY | | | | 16, 200 | | | | |
| aminer | 4e Facility Neme (If | | | | | | 4b. City, Town, or | | | | | | |
| | | | GENERAL | HOSP e (In yrs. las | | nder 1 Yeer | WESTMI | | | ROLL | | | |
| al or | 5. Sociel Security No. 215-36- Usual Residence of | 8314 | DM 2∏ F | 5 9 | Mor | ths Days | Hours Mir | . (Month, D | 1 9 4 0 | 9. Birthplace (State or For Country) MARYLAND | | | |
| | 10e. Stete | 10b. County | | | own or Location | | | 10d. Inside City | | | | | |
| to | MD. | CARROL | <u>.</u> | WES | TMINST | ER | | 1 May Yes 2 □ N | | | | | |
| Director | 10e. Street and Num | nber | | | 10 | . Zip Code | | | 10g. Citizen of V | Whet Country? | | | |
| ie i | 68 S. B | ISHOP S' | Г. | | | 2115 | 7 | | USA. | | | | |
| by Funeral | 11. Marital Status 1 □ Never Merrie 3 ☒ Widowed | | 12. Was Decedent Armed Forces? 1 Yes 2 X If Yes, Give Yeer or Detes: | Ever in U,S. No | | ecedent of h specify Cub es 2 No | lispanic Origin? (en, Mexican, Pue Specify: | Specify Yes or N nto Rican, etc.) | o- 14. Race Blace Specify | e - American Indian, ck, White, etc. | | | |
| te B | (6 | 15. Decedent's Ed | ucation | 1 | 6a. Decedent's | Usuel Occup | pation | addina | 16b. Kind of Bu | usiness/Industry | | | |
| Completed | Elementary/Secon | ify only highest gradendary (0-12) | College (1-4or : | 5+) | life. DO NO | OT use retire | pation during most of wo d) | orking | | | | | |
| Con | 1 | 2 | | | CLERK | | | | | STORE | | | |
| Be | 17. Father's Name (| | | | | | 18. Mother's Na | | e, Meiden Sumem | 10) | | | |
| To | | JOHN | | SPURR | | | | | NOWN | | | | |
| | 19a. Informant's Na | | | | | | | | | Stete, Zip Code) 2110 | | | |
| | DAVID G. | | , JR | | 734 CR | (Name of | DAD SCH | | | ANCHESTER, | | | |
| | 20a. Method of Disposition 1 Burial 2 Cremetion 3 Removel from State 4 Donetion 5 Other (Specify) 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) METRO CREMATORY 1 / 19 / 200 BALTIMOR | | | | | | | | | | | | |
| | | 5 ☐ Other (Specify | | MET | | MATOR | | | | | | | |
| any injury | 21. Signature of Fu | mo . 7 | 200 | | | | | | | AL HOME R, MD. 2115 | | | |
| er | Immediate Cause (I disease or condition resulting in death) | | a. Arry | Due to (or as | MYO s a consequence | cons | m | NISME | non | Onset and Deet | | | |
| Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Due to (or es e consequence of): | | | | | | | | yn s | | | | | |
| Physician/Medical | thet initiated events resulting in death) L | | d | | | | | | | | | | |
| SICI | Pert II. Other eignifi | cant conditions co | entributing to death b | ut not resuitir | ng In the underly | ing cause gi | ven in Part I. | 23b. Die | d tobacco use co | ntribute to the cause of de | | | |
| | | | | | | | | 10 | Y 90 20 XNO | 3 Probably 4 Unk | | | |
| | 24a. Was an auto performed? | | | | | | | | s an autopsy formed? | 24b. Were autopsy findir evailable prior to completion of cause of death? | | | |
| pleted b | | | | | | | | 1□ | Yes 2 No | 1 ☐ Yes 2 No | | | |
| Completed b | | | | | | | 26. Place of De | eath (Check only | one) | | | | |
| Be Completed by | 25. Was case referr | - | | | | 1 | | The state of the s | | | | | |
| Be | 25. Was case referr exampler? | | Hospital: 1 ☐ Inpatio | ent 2 ER | /Outpatient 3[| J DOA | | Home 5 Res | sidence 6 DOth | | | | |
| To Be | examiner? 1 Yes 2 1 27. Manner of Death 1 Statural 2 Accident | No 5 Pending Investigation | 28e. Date of Inju (Month, De | ry 28 | VOutpatient 3E 3b. Time of Injury | 28c. Inju Wo | 4 LI Nursing | Home 5 Res | how injury occur | red | | | |
| To Be | examiner? 1 Yes 2 2 27. Manner of Death | No 5 ☐ Pending | 28e. Date of Inju (Month, De | y Year) 28 | Bb. Time of Injury | 28c. Inju Wo | ry at rk? | Home 5 Res 28d. Describe | how injury occur | | | | |
| To Be | examicer? 1 Yes 2 2 2 27. Manner of Death 1 Statural 2 Accident 3 Suicide 4 Homicide | 5 Pending Investigation 6 Could not be determined | 28e. Date of Inju (Month, De 28e. Place of Inju building, et | ury - At home c. (Specify) | bb. Time of Injury M Me, farm, street, fa | 28c. Inju Wo | y at rk? Yes 2 □ No | 28d. Describe 28f. Location City or To | Street and Numbown, Stele) e cause(s) and ma | rred ber or Rurel Route Number, | | | |
| Be | examiner? 1 Yes 2 1 27. Manner of Death 1 Watural 2 Accident 3 Suicide 4 Homicide | 5 Pending Investigation 6 Could not be determined | 28e. Date of Inju 28e. Place of | ury - At home c. (Specify) | bb. Time of Injury M Me, farm, street, fa | 28c. Inju Wo | y at rk? Yes 2 □ No me, date and pler optnion, deeth occ | 28d. Describe 28f. Location City or To | Street and Numbown, Stete) e cause(s) and min, date and place, | over or Rurel Route Number, | | | |
| edicai Certification: To Be | examicer? 11 Yes 2 12 27. Mannar of Death 1 Statural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) | 5 Pending Investigation 6 Could not be determined | 28e. Date of Inju 28e. Place of | ury - At home c. (Specify) | bb. Time of Injury M Me, farm, street, fa | 28c. Inju Wo 1 Control of the time was a state of the | y at rk? Yes 2 □ No me, date and pler optnion, deeth occ | 28d. Describe 28f. Location City or To | Street and Numbown, Stete) e cause(s) and min, date and place, | over or Rurel Route Number, anner as stated. and due to the cause(s) | | | |
| edicai Certification: To Be | examicer? 11 Yes 2 12 27. Mannar of Death 1 Statural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) | 5 Pending Investigation 6 Could not be determined | 28e. Date of Inju 28e. Place of | y Year) 28 y Year) 28 ury - At home c. (Specify) of my knowle examination | bb. Time of Injury M e, farm, street, fa dge, deeth occur a and/or investig | 28c. Inju Wo 1 Control of the time was a state of the | y at rk? Yes 2 □ No me, date and pler optnion, deeth occ | 28d. Describe 28f. Location City or To | Street and Numbown, Stete) e cause(s) and min, date and place, | over or Rurel Route Number, anner as stated. and due to the cause(s) | | | |

DHMH 16 Rev 6/95



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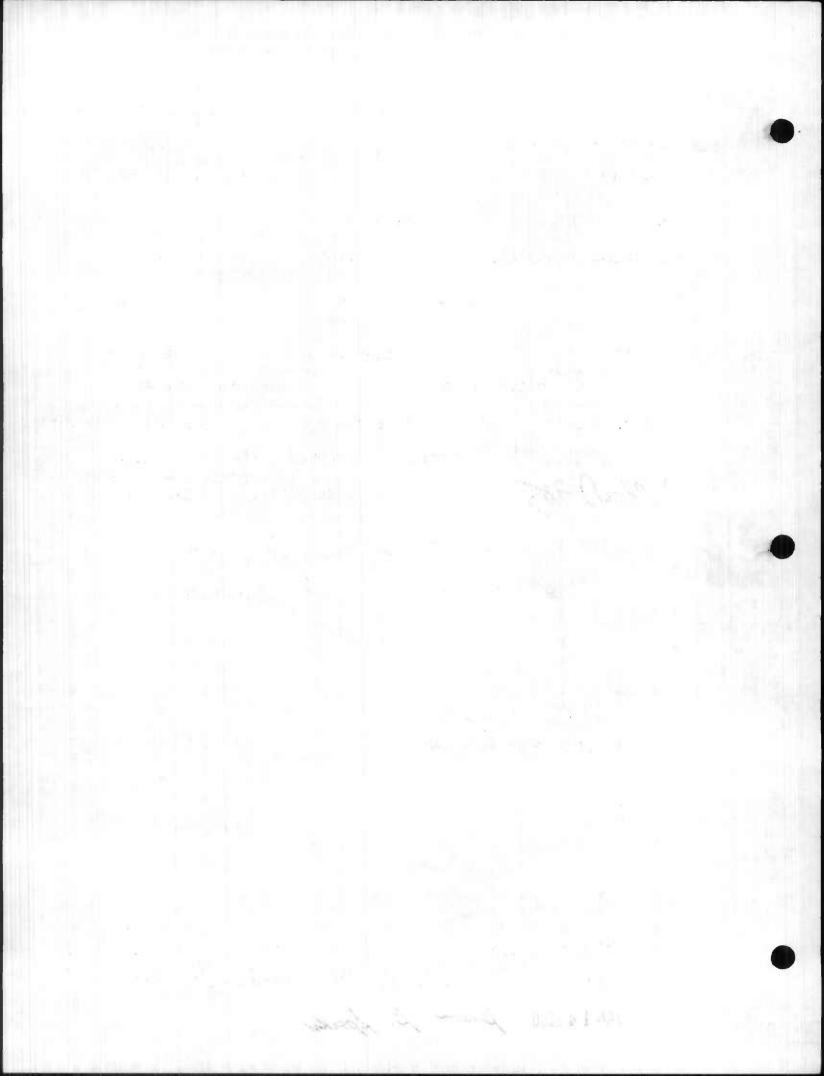
| | | | | | State of M | arylan | | partment o | | and Mental Hy | ygiene (| 02 | 40 | 3 |
|-----------|--|----------------|--|----------------------------|----------------------------------|----------------|---------------------|-----------------------------------|-----------------------------------|--|----------------------------|------------------------------------|------------------------|-----------|
| | | | 1. Decedent's Name (Fin | 2. Date of D | eath | 3 | | Death | | | | | | |
| | | | | | JESSE (| CARR | OLL ' | TAYLOR | | JAN. | 13, 200 | Year | :30 | AM |
| | | | 4a Facility Name (If not | institution, give | street and number, | | | | 4b. City, To | wn, or Location of Dea | | | | |
| (| | | 629 SPRIM | NG MII | LS RD. | | | | | TMINSTER | | ROLL | | |
| | Funeral Director | | 5. Social Sacurity Number 214-01-175 Usual Residence of Dac | 52 . | 8X 7. A(✓ M 2□ F | 9a (In yrs. 81 | Yrs. | y) If Under 1 Y Months D | aar If Under ays Hours | Min. 8. Date of B (Month, D | | 9. Birthplace Country) MARYL | | r Foreign |
| | land wa | | | . County | | 10c. City | , Town or | Location | | | | 10d. | Insida Ci | ty Limits |
| | Mery | jo | MD. C | ARROL | L | WE | STMI | NSTER | | | | | 1 🗆 Yes | 2[XNo |
| | or 28 | 9 | 10e. Street and Number | | | | | 10f. Zip Co | da | | 10g. Citizan of V | What Country | | |
| | 23a c | a | 629 SPRIN | G MIL | LS RD. | | | 211 | 57 | | USA. | | | |
| | | ne. | 11. Marital Status | | 12. Was Decedant Armed Forces | , | S. 13 | I. Was Decedant | of Hispanic Orl Cuban, Maxical | gin? (Specify Yas or N n, Puarto Rican, etc.) | | e - Amarican ck, Whita, atc. | ndian, | |
| 20 | of seffe | | 1 Navar Marriad 3 Widowed 4 | | 1X Yas 2 If Yes, Give | | - | 1□ Yas 2X | No Specify: | | Specify | /: tatt=m | - | |
| Ş | houn hour | | | Decedent's Ed | Year or Datas. | WW I | | edant's Usuai O | counstion | | 16b. Kind of Bu | WHIT | | |
| 1215-0020 | The law requires that the deeth certificate be executed the second at the law requires that the deeth certificate be executed to be second to be seen signed by the attending physician and pega 2 should be detached for use as the buriel-transit on the second to be seen that the profile of the second to be seen that the second to the seco | Se l | (Specify or | nly highest gra | de completed) | - 1 | (Gir | e kind of work of DO NOT use r | one during mos | t of working | Too. Italia of Di | adiria da iri ado | ., | |
| 212 | with jiene. | E | Elemantary/Secondary 1 2 | y (0-12) | Collega (1-4or | 5+) | | SUPERV | ISOR | | RAILR | OAD | | |
| and | 軍工党を | Se C | 17. Father's Nama (First | , Middle, Last) | | | | | 18. Mothe | ar's Name (First, Middl | e, Maiden Sumam | 10) | | |
| <u>N</u> | | | | L. | CLARK TA | YLOR | | | MA | RY AGNES | KNIGHT | | | |
| lary | SP E | | 19a. Informant's Name/F | | Type, Print) | | | | | er or Rural Route Num | | | | |
| 2 0) | end feelth m 27 her tr | - | MARY E. T | | -WI | | | SPRING position (Neme | | RD., WE | STMINST 20c. Location - | | | 1157 |
| 0 | T it its | | 20a. Mathod of Disposition 1 X Burial 2 ☐ Cre | emation 3 🗆 | | 0 | em <i>etery</i> , c | rematory or othe | r place) | 1/16/20 | | | | - |
| altimore, | | - | 4 Donation 5 21. Signature of Funeral | | | DEE | | RK CEM | | j | | | | ٠. |
| g D | Depa Impo any i | | I May | 1171 | K | | | | | FLETCHER T., WEST | | | | 157 |
| | | + | 22a Parti Enter the di | 0 /0 | alications that cause | d the death | | | | | | | proximat | |
| | Dhusisian | | 23a. Part1. Entar tha dis shock, or haart feil | ura. List only | ona causa on aach i | ina. | 50 1101 6 | into the those o | c) 119, 5451 45 | our of respiratory | ^ | Int | erval Bet set and I | ween |
| | | | Immediata Causa (Finai | | A | ca Do | w | mo Co | - dea | 1 Inf | ancho | | 1 .11 | 0 |
| | Examiner | | disaesa or condition resulting in death) | | 8. | Due to (o | r es e cons | equence of): | ^ | 0 | | | no | NI) |
| | n & | je | | | 1'50 | Do. | w C | he | ant | 0,000 | 0 | | | |
| | acute and trans | | Sequentially list condition if any, leading to immed | ons, | b | Due to (o | es e cons | equence of): | | -002 | | | | |
| Ď, | cian g | E E | any, leading to immed cause. Enter Undarlying Causa (Disaasa or injury | lata | C | | | | | | | | | |
| 2/60 | the the | 200 | that initiated avents rasulting in death) Last | | V | Dua to (or | as a cons | equance of): | | | | | | |
| X | ding se as | Me | | | d | | | | | | | | | |
| ROX | deeth certificate be executed Examine of a strength and and a strength and a strength and a for use as the buriel-transit | Clar | Dad II. Other steeldises | l condition of | | | dain to also | | i i- D | 22h Di | d tobacco use co | nedbute to th | | of death? |
| o | the d | nys | Part II. Other significant | O A | ontributing to death t |) D | ating in the | underlying caus | e given in Part | | Yes 2 No | 3 Probeb | | |
| 7 | s that | 2 | dia | ledes | mel | uth | 1 | | | | 3 100 2)4110 | | , | |
| ecords, | | | h | sper. | lyndo | | 4 | | | | is an autopsy formed? | 24b. Wara availa | autopsy f | lindings |
| ပ္ထ | aw resis been 2 sho | pie | | 21 | -0 | | • | | | | | compl of dea | ation of c | ause |
| r | The little ha | E | | | | | | | | 10 | Yes 2 No | 1 🗆 Y | as 2 | No |
| VII | ysicien: is cartifica director, p | 200 | 25. Wes casa refarred to axaminar? | medical | | | | | 26. Place | a of Daath (Check only | (one) | | | |
| 0 0 | 2 00 | 0 | 1□ Yas 2☑ No | | Hospital: 1 ☐ Inpati | | ER/Outpat | | | ursing Homa 5X Ra | sidence 6 Oth | ar (Specify) | | |
| | tending Ph leath. or: After th tha funeral | ou. | 27. Manner of Deeth 1 Netural 5 [| ☐ Panding | 28a. Data of Inju (Month, De | y Year) | 28b. Tima Injun | | Injury et Work? | | how injury occur | red | | |
| S | death. | Cat | 2 ☐ Accidant 3 ☐ Sulcide 6 [| invastigation Could not be | | ium. At he | on a farm | M etract factors of | 1 Yes 2 | | (Street and Numb | her or Bural B | oute Mum | her |
| UNISION | D afte | Certification: | 4 ☐ Homicide | datarmined | building, a | ic. (Specify | /) | straet, factory, of | iice | City or T | own, Stele) | Der Of Figral Fi | Date Ivaii | iver, |
| | To the Hospital or Att within 24 hours after d To the Funeral Direct completaly filled in by | | | | | | | | | nd place, and dua to th | | | | |
| | To the Hospital within 24 hours To the Funeral completaly filled | edical | | | | f axaminal | | | | oth occurred at the time | | | | 6) |
| | To the vithin 2 To the comple | Σ | 29b. Signature and titla | of certifiar | | | | 29c. L | censa numbar | 1 | 29d. Date signe | Month Da | , Year) | |
| | | | D | saal | lang' | | | Ţ | > 230 | 15 | 1 | 14/20 | 000 | |
| | | | 30. Nama and addrass o | of person who | complated cause of | | 23a) (Typ | e/Print) 1 L | 4 | 100A .4 | 7 | 211 | 57 | |
| | | | D.S.KAL | AK14 | 21/ | was | treme | YOU [| U. | V col hurles | ш, 199 | cil. | 1 | |

State Registrar

31. Data filad (Month, Day, Year)

JAN 1 4 2000

G. Sparks



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death Decedant's Nama (First, Middle, Last) 2. Dete of Death 3. Time of Deeth Month Yaar January 6, 2000 Mary Louise Thomas 4 PM 4e. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Shore Nursing & Rehabilitation Center Caroline County Denton H Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) Min. 4 May 28, 19 Birthplaca (State or Foreign Country) 5. Sociel Security Number 7. Aga (In yrs. last birthday) 1□ M 2X F 215-38-1645 82 Maryland Usual Rasidence of Dacedant 10b. County 10c. City, Town or Location 10d. Inside City Limits Oueen Anne's Chester 1 Yas 2 No 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 407 Ellicot Drive 21617 USA 12. Was Dacedant Evar in U,S. Armed Forcas? Was Decedant of Hispenic Origin? (Specity Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Rece - Amarican Indian, Bleck, White, atc. 1 ☐ Yes 2 ☐ No If Yas, Give Yeer or Datas: 1 ☐ Nevar Married 2 ☐ Married Specify: White 1 ☐ Yas 2 X No 3€Widowed 4 □ Divorced 15. Decedant's Education (Specify only highast grada complated) 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) Homemaker 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maidan Sumema) James Howard Dadds Manie Lewis 19a. Informant's Name/Ralationship (Type, Print) 19b. Melling Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Mary Jo Connell - Daughter 523 Chesapeake Ave. Stevensville, MD 20b. Pleca of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, State 20a. Malhod of Disposition 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donetion 5 ☐ Other (Specify) January 10, 2000 Stevensville, MD Stevensville 21. Signature of Fuperal Service Licenses 22. Name end Address of Fecility Fellows, Helfenbein & Newnam Funeral Home 106 Shamrock Rd. Chester, Maryland 21619 Part 1. Enter the disease or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. immediata Causa (Final disaase or condition rasulting In death) Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown

Physician /Medicai Examiner

ician end bunal-transit

physician s the bunal

950

signed by the e

should

page 2

funeral

To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral

Division of Vital Records, P.O. Box 68760,

Examiner

Physician/Medical

p

Completed

Be

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Certification:

Medical

Physician

/Medical

Examiner

10a State

11

Director

Funeral

p

Funeral

Director

item 27 is marked other than "natural", or items 23s or 28s-f show other traumstic event, the Medical Examination must be notified at

permit. Peges 1 and 2 should be filed within 72 hours after death 1 Department of Heelth and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23s any Injury or other traumetic avant

Saltimore, Maryland 21215-0020

the Maryland

With

Sequantially list conditions, if any, laading to immadiata causa. Entar Underlying Ceusa (Disaasa or Injury that initiated avants rasulting in daath) Lest

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f.

24e. Wes an autopsy performed?

24b. Wara autopsy findings available prior to completion of causa of deeth?

2 No 1 ☐ Yas 26. Placa of Death (Check only ona)

1 ☐ Yaa 2 ☐ No

25. Wes case refarred to medical axaminar? 200 No 1 Yes

5 Panding

6 Could not be datermined

1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA investigation

28b. Tima of

28e. Place of Injury - At homa, farm, street, factory, office building, atc. (Spacify)

28c. Injury at Work? 1 ☐ Yas 2 ☐ No

Other: Nursing Home 5 Residence 8 Other (Specify) 28d. Dascribe how injury occurred

28f. Location (Street and Number or Rural Routa Number, City or Town, State)

29a. Certifiar (Check only one)

27. Mannar of Death

1 Netural 2 Accidant

3 Suicida

4 Homicida

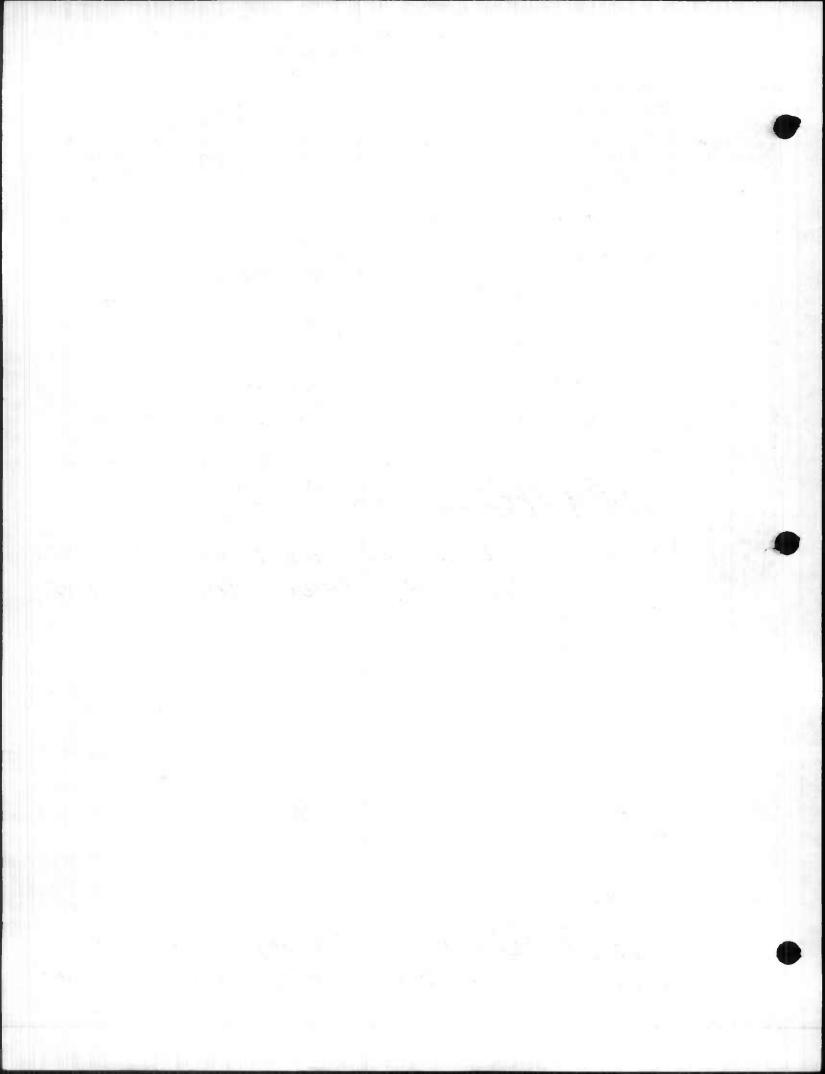
Certifying Phyalcian: To tha best of my knowledga, daath occurred at tha time, data and placa, and due to the ceusa(s) end manner as steted. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

2 Medical Examiner: On the basis of axamination and/or invasligation, in my opinion, daath occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Data signed (Manth, Day, Year)

and address of person who complated causa of daath (Itam 23a) (Type, Print) WD 2/9 S. washington St Easton MD 2/60 5. mo

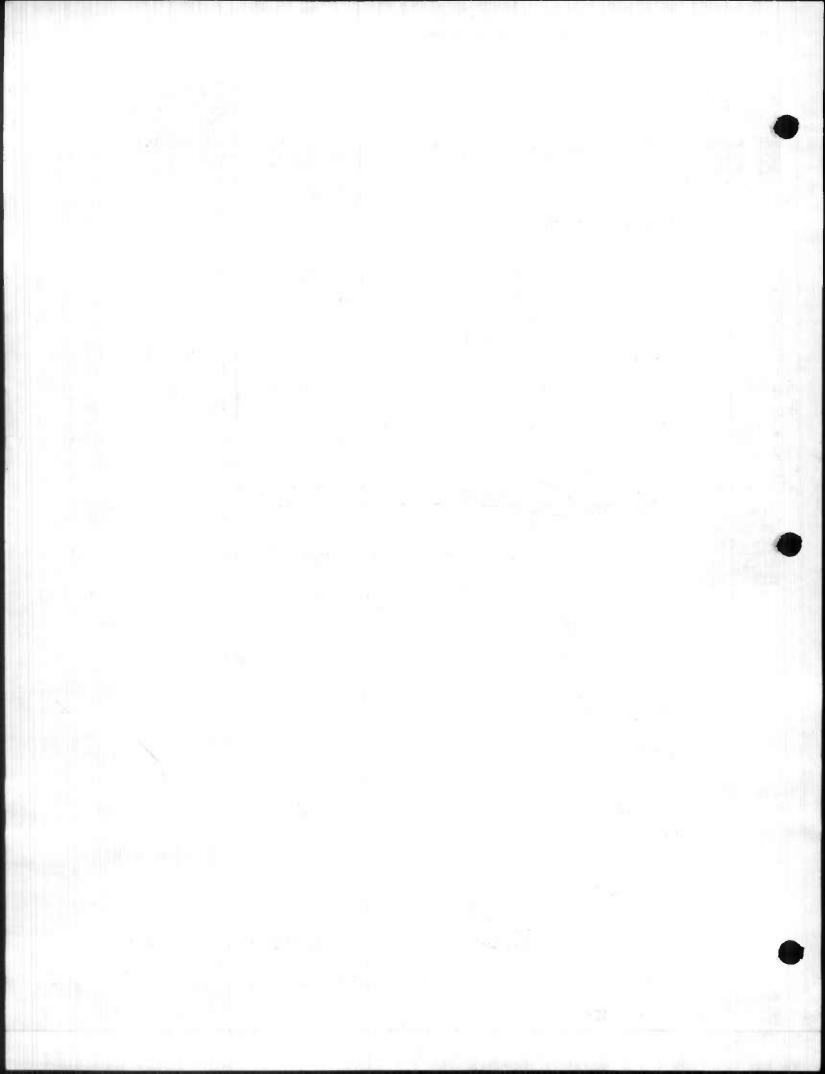
State Registrar 32. Ragister's Signetura



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 0 2 4 0 5

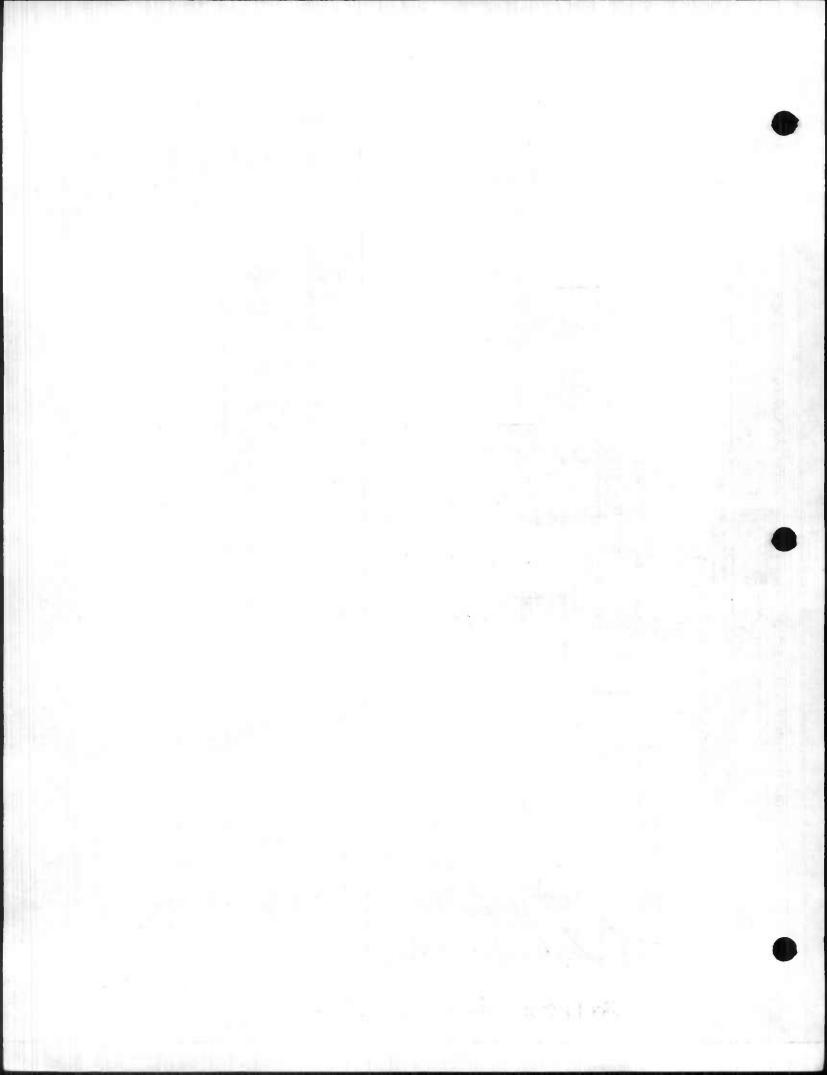
| | | | | | | Cert | ificate o | f Death | | Reg. No. | 0 (| 6400 | |
|----------------------------|---|----------------|---|--|-----------------------|------------|----------------------------------|---|---|-----------------|---------------|---------------------------------------|------|
| | | | 1. Decedent's Neme (First, Middle, La | st) | | | | | 2. Data of De | ath | | 3. Tima of Death | |
| | Physici /Medi | | Elsie Mae | Thomps | on | | | | Jan | 11 2 | Year 2000 | 7:50 A | M |
| | Exami | | 4e. Fecility Name (If not institution, giv | | | | | 4b. City, Town, or | Location of Deat | | ty of Death | | |
| 7 | | | Genesis Elder | Care - The | Pine | es | | Eas | ston | Ta | albot | | |
| | Funerai | | 5. Social Sacurity Number 6. S | | n yrs. lest bi | rthday) | If Under 1 Yes Months Day | | | th | 9. Birth | piece (State or Fora | ign |
| 4 | Director | | 213-16-8890 | LIM ZAJF | 77 | Yrs. | | | | , 1923 | | ware | |
| | pug *_ | | Usual Residence of Decedent 10e. State 10b. County | 10 | c. City, Tow | m or Loca | ntion | | | | - Т | 10d. Insida City Limi | lê m |
| | Aenyti Peho | 0 | | | (5) | | | | | | | 17 Yas 2 □ N | |
| | h the Meryland r 28a-f ehow | Director | Maryland Dorches | ster | Cambr | '1dge | 10f. Zip Code | | | 10g. Citizan o | 1 Mart Cour | | |
| | 23a or | | 701 Race Street | | | | | | | | Wilet Cou | nuyr | |
| | 72 hours after death with the Meryland natural, or items 23a or 28a-f show areal Examiner must be notified at | Funeral | 11. Marital Status | 12. Wes Decedent Eva | r in U.S. | 13. W | 21613 | | Specify Vas or No | USA 14. Br | ace - Americ | can Indian | _ |
| 0 | fter dea | Fun | 1 ☐ Nevar Married 2 ☐ Married | 12. Wes Decedent Eva Armed Forces? 1 ☐ Yes 22300 | 0,0. | H | es, specify Co | of Hispanic Origin? (Suben, Mexican, Puer | to Rican, atc.) | BI | eck, Whita, | | |
| 020 | af, or | by | 30XWidowed 4 □ Divorced | If Yes, Give Yeer or Detas: | | 1[| □Yas 2\UXN | lo Specify: | | Spec | ity: B1 | ack | |
| Maryland 21215-0020 | n 72 ho | Completed | 15. Decedent's Ed | lucation | 16e | . Decede | nt's Usuai Occ | cupation | | 16b. Kind of | Business/In | dustry | |
| 215 | S | pje | (Specify only highest gra | College (1-4or 5+) | | life. Do | nd of work dor NOT use reti | ne during most of wo ired) | rking | | | | |
| 21 | | 00 | 12th | | P | acke | r | | | Cold W | ater | Seafood | |
| nd | | Be (| 17. Fether's Neme (First, Middle, Last) | | | | | 18. Mother's Ne | me (First, Middle | , Maiden Sume | me) | | |
| yla | should be filed nd Mentel Hygi marked other umatic event, I | 2 | Oscar Sherman I | Elliott, Sr. | | | | Myrt1 | E. Til | ghman | | | |
| Jar | 2 6 6 2 | | 19e. Informent's Neme/Ralationship (| | | o. Mailing | Address (Stre | et end Number or R | urel Route Numb | er, City or Tow | n, State, Zip | Code) | |
| _ | こまるト | | Rodney Sherman | | | | | Street, | - T | | | | |
| 0 | 9 0 1 | | 20e. Mathod of Disposition 1 ☑ Burial 2 ☐ Cremetion 3 ☐ | | Ob. Place o cemete | ry, creme | tion (Name of tory or other p | olece) | Date | 20c. Location | - City or To | own, Steta | |
| Ë | | | 4 ☐ Donetion 5 ☐ Other (Specify | 1) | Thom | pson | town Ce | emetery | 1/15/00 | Thomps | ontow | n. Md. | |
| Baltimore, | permit. Pege Depertment of Important: If eny injury or | | 21. Signeture of Funetal dervice Licer | 560 | _ | 22. 1 | Name end Add | drass of Fecility Smith Fur | | | | | |
| | 40 E 6 d | | 1 | | | | | x 1687, I | | | d 21 | 601 | |
| | | | 23e. rt1. Entar the diseasa, or con shock, or heart feilure. List only | ications thet causad that | deeth. Do | not enter | tha moda of d | lylng, such es cardia | c or raspiretory a | rrest, | | Approximate Intervei Between | |
| | Physician | | | 1 | | | | | | | | Onset and Death | |
| 71 | /Medical Examiner | | Immediate Cause (Final disease or condition | · Acute | and | chn | mic 1s | enal fa | there | | | years | |
| н | Examinici | L. | resulting in death) | o. Acute | to (or es e | conseque | ence of): | | | | | | |
| | be sign | line | | 1 Atkow | sder | 0315 | gener | relized | | | 1 | years | |
| - | icata be axecuted physician and s the burial-transit | Examiner | Sequentially list conditions, if any, leading to immediate | Due | to (or es a | conseque | ope of): | | | | 0 | | |
| 68760, | requires thet the death certificata be axecut een signed by the attanding physician and hould be detached for use as the burial-tra | | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | C | | | | | | | | | |
| 387 | phys the | Medical | resulting in deeth) Last | Due | fo (or es e | conseque | nce of): | | | | i | | |
| × | certifica Inding ph use as t | | | d | | | | | | | | | |
| Box | eath ce attandi | ciar | | | | | | | | | | | |
| P.O. | het the death ed by the atta detached for | by Physician/ | Pert II. Other algnificent conditions of | ontributing to death but no | of rasulting in | n tha und | erlying cause | given in Pert I. | | | | the cause of deat | |
| | res thet the signed by be detact | P | Hypertension | | | | | | 10 | Yes 2□ No | 3 ☐ Pro | bably 4 Unkno | wn |
| ds | sign d be | | 1. | | | | | | 24a Wes | an autopsy | 24b. W | ere eutopsy findings | 9 |
| Ö | _ 10 00 | Completed | Anemia | | | | | | | rmed? | av co | eilebie prior to mpletion of cause | |
| Re | has has | dm | , | | | | | | | | of | death? | |
| a | ifclan: The certificate rector, pag | ပိ | Dr. War and and the artist | | | | | | 10 | | 1[| Yes 2 No | |
| = | | o Be | 25. Wes case referred to medical examiner? 1 Yes Ze No | Hospital: | аП г р(0 | | -57.004 | Other: \ | eth (Check only o | | | | |
| of | Phys r this aral di | 5 | 27. Menner of Deeth | 28e. Dete of injury (Month, Day Ye | 2 □ ER/Ot 28b. | Time of | 3 DOA 28c. In | | dome 5 ☐ Resident Re | | | y) | |
| Division of Vital Records, | Attending Ph ir deeth. ector: After th by the funeral | tion | PSNeturel 5 ☐ Pending 2 ☐ Accident Investigation | | ar) I | Injury | | /ork? □ Yes 2 □ No | | | 1000 | | |
| /18 | Attendit r deeth. octor: A by the fu | flea | 3 ☐ Suicide 6 ☐ Could not be | 286. Piece of injury - | At home, fe | rm, stree | t, fectory, offic | :e | | | ber or Rure | al Route Number, | |
| Ö | afta Dire | Certification: | 4 Homicide | building, etc. (S | pecify) | | | | City or To | vn, Stete) | | | |
| | To the Hospital or Attent within 24 hours aftar deel To the Funeral Director: complately filled in by the | | 29a. Certifiar Certifying Ph | ysician: To the best of m | y knowledge | , deeth o | ccurred et the | time, date and piece | e, end due to the | ceuse(s) end m | anner as s | tated. | |
| | n 24 n 24 ne Fu | edicai | (Check only 2 Medical Exemone) | Inar: On the besis of exa end menner steted | minetion en | d/or Inves | stigetion, in my | opinion, deeth occu | rred et the time, | dete end place | , and due to | the cause(s) | |
| | To the To the Com | Σ | 29b. Signeture and title of certifier | 2001 | 2 | | 29c. Lice | inse number | 000 | 29d. Dete sign | | | |
| | | | | MHELLE) | / | | | 1125 | 159 | 1 | 11.0 | 0 | |
| | | | 30. Neme end address of person who | completed cause of deeth | (Item, 23e) | (Type, Pr | int) | 0 . | , , | / | ho. | | |
| | | | I'IICHAEL CROW | TIMD - | 508 | 3 1 | DLEWI | M) HVEN | ناك ا | MISTON | | 21601 | - |
| | Sta | | 31. Data filed (Month, Dey, Year) | 32. Registrar's | Signature | B | . 330 | oute | | | / | | |
| | Registr | ar | JAN 12 | 2000 | | 3 | 1 | | | | | | |



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

| ian | 1. Decedent's Name (First, Mi | | | | | | | | 2. Date of De Month | ath Day | Year | 3. Time of Death | |
|-----------------------|--|------------------------|--|---------------------------|---|-----------------|----------------|------------|--|---|------------------------|--|--|
| ical | JAMES FREDR | | THOMPSON | | | | Ab Ciby Tow | | JANUAR ation of Death | | | 8:11 AM | |
| ner | FORT WASHING | | | w) | | | FORT W | | | | | DCF | |
| | 5. Social Security Number | 6. Sex | 7. | Age (In yrs. | last birthday) | If Under 1 Y | ear If Under 2 | | Hrs. 8. Date of Birth 9. Birtholace (Sta | | | place (State or Foreign | |
| | 217-42-6720 | 1/2 | Months Days Hours | | | | | | JUNE 5 | | MARY | TLAND | |
| | Usual Residence of Decedent 10a. State 10b. Cour | nty | | 10c. Cit | ly, Town or Loc | ation | A A | | | | 1 | IOd. Inside City Limits | |
| | MARYLAND CHAI | RLES | | BRY | ANS ROZ | AD | | | | | 1⊠ Yes 2□ | | |
| 2000 | 10e. Street and Number | | | | | 10f. Zip Co | de | | | 10g. Citizen of V | What Cour | ntry? | |
| | 7313 JUDY DR | | | | | 2061 | | | | UNITED | | | |
| | 11. Marital Status 1 □ Never Married 25 W 3 □ Widowed 4 Moivord | arried | 12. Was Decede Armed Force 1 Ves 20 If Yes, Give Year or Date: | s? XNo | If Yes, specify Cuban, Mexican, Pue | | | | | | ck, White, | can Indian, etc. | |
| ŀ | 15. Deced | lent's Educ | cation | | 16a. Decede | ent's Usual O | ccupation | of workin | | 16b. Kind of Bu | usiness/in | dustry | |
| | Elementary/Secondary (0-12 | | College (1-4c | r 5+) | life. D | O NOT use n | etired) | or working | | | | | |
| 1 | 12th 17. Father's Name (First, Midd | la / set) | | | MACHI | NE OPE | | e Nama | /Eiret Middle | FEDERAL Maiden Sumam | | ERNMENT | |
| | the state of the state of | | | | | | | | | | | N | |
| | AARON THOMPSON ANNIE CECELIA SAVOY THOM 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, S | | | | | | | | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) EX-WIFE FRANCES THOMPSON / WIFE 7313 JUDY DRIVE BRYANS ROAD, MARYL | | | | | | | | | | | | |
| | 20a. Method of Disposition 1 Ø Burial 2 ☐ Cremetic | o 3 🗆 🗈 | emovel trom Ste | | Place of Dispos cemetery, crem | | | | Date | 20c. Location - | City or To | own, State | |
| | 4 Donation 5 Other | | omovai trom Sta | ST | . CHARL | ES CEM | ETERY | 1/ | /20/00 | GLYMON | T, M | ARYLAND | |
| | 21. Signature of Fundrul Sarvi AYULL LYDIA C. TI | א כוב | MD 20640 | | | | | | | | | | |
| | 23a. Part1. Enter the disease, shock, or heart tailure. Ultimediate Cause (Final disease or condition resulting in death) | ist only on | | | ARRYTH | | | | | | 1 | Approximate Interval Between Onset and Death | |
| | | | CARDIO | | or as a consequ | ience of): | | | | | | YEARS | |
| | Sequentially list conditions | C b | CARDIO | | or as a consequ | ience of): | | | | | 1 ' | ILANS | |
| | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | J. | CORONA | | TERY DI | | | | | | 13 | YEARS | |
| | that initiated events resulting in death) Last | 1. | | | | | | | | | | | |
| | Det II Other significant and | | and the state of t | | | | | | | obacco use contributa to the cause of death | | | |
| | Part II. Other significant cond | INOPES CON | s contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use con 1戊 Yea 2□ No | | | | | | | | | | |
| 24a. Was an perform | | | | | | | | | av | ere autopsy tindings vailable prior to empletion of cause death? | | | |
| | | | | | | | | | 1短 | Yes 2□ No | 10 | □Yes 2□No | |
| | 25. Was case referred to medi examiner? | - | | | | | | of Death | (Check only o | one) | | | |
| | 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pen 2 Accident inve | | 28a. Date of In (Month, I | | ER/Outpatient 28b. Time of Injury | | Other: 4 Num | 21 | | dence 6 Oth | | fy) | |
| | 3 Suicide 6 Cou | ld not be irmined | | njury - At heetc. (Specil | ome, farm, stre by) | et, factory, of | fice | 21 | 8f. Location (City or To | Street and Numb wn, State) | per or Run | al Route Number, | |
| an III Ca | | | tysician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. When the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) | | | | | | | | stated. o the cause(s) | | |
| edical certification: | 29a. Certifier 1 Certification 1 Certification 2 Medic | ying Phys al Examin | er: On the basis | and manner stated. | | | | | | | | | |
| | (Check only 2 Medic | al Examin | er: On the basis | stated. | | 29c. Li | cense number | | | 29d. Date signe | d (Month, | | |
| 300 | (Check only 2 Medic | al Examin | er: On the basis | stated. | MD | 29c. Li | cense number | | | 1 | d (Month. | Day, Year) | |

DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 1:55 AM anuary 11, 2000 Wanda Cecelia Trusen /Medical 4b. City, Town, or Location of Death 4e Facility Neme (If not institution, give street and number) 4c. County of Death Examiner Doctor's Community Hospital Lanham Prince George's If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Dete of Birth (Month, Day, Year)
Nov. 19, 1917

8. Birthplace (State or For Country)
Pennsylvania 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Deys Hours Months 1□ M 2⊠ F Yrs. 144-07-6356 82 Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahon filed within 72 hours after death with the Maryla Hygiene. Wher than "natural", or frams 23a or 28e-f show and, the Maries Essioner mant be inculted. 1 Yes 2 No Director Maryland Prince George's New Carrollton 10a Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 20784 8314 Cathedral Avenue U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black White etc. 1 ☐ Yes 2 ☒ No 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White À 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuet Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Homemaker Own Home mportant: If item 27 is marked other any injury or other traumatic event, it 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) Be 1 and 2 should be Haalth and Mental Anthony Kelly Anna Kolonowski 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) Paul H. Trusen - Husband 8314 Cathedral Avenue, New Carrollton, MD 20784 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition Dete 20c Location - City or Town, State 6 1 🕅 Buriel 2 ☐ Cremetion 3 ☐ Removal from Stete **Department** Gate of Heaven Cemetery 01/15/00 Silver Spring, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name end Address of Facility Gasch's Funeral Home, P.A. 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart fature. List only one cause on each line. 4739 Baltimore Avenue, Hyattsville, MD 20781 Approximate Interval Between Onset and Death HYPERTENSIVE ARTERIOSCLEROTIC CARDIOVASCULAR **Physician** /Medical Immediate Cause (Finel 5years diseese or condition resulting in deeth) Examiner Due to (or as e consequence of): Examiner the death cartificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Due to (or as e consequence of): physician the burial Box 68760. Physician/Medical Due to (or es e consequence of): Pert tj. Other significant conditions contributing to death but not resulting in the underlying cause/given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.O. 3 Probably 4 Unknown 1 Yes 2 No PANDANT DIAGETES Records. þ 24b. Were autopsy findings available prior to completion of cause of deeth? Completed 24a. Wes en eutopsy performed? WE FULMONARY DISEASE 1 Yes 20 No 1 TYes 2 No Division of Vital 25. Wes case referred axaminer? 8 26. Place of Deeth (Check only one) 2th No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Inpatient 2 □ ER/Outpatient 3 □ DOA Certification: To 28a. Dete of Injury (Month, Day Year) 27. Menger of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 1 Netural or Attending 5 Pending 1 Yes 2 No aftar death. investigetion 2 Accident Director: / 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Piece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homlcide

24 hours at Funeral Dietaly filled i Hospital To the F

DHMH 16 Rev 6/95

Registrar

Medicai

29e. Certifier

(Check only one)

William Rosson, M.D. 31. Dete filed (Month, Day, Year) JAN 1 4 2000

and address of person who completed cause of death (Item 23a) (Type, Print) 5701 85th Avenue, New Carrollton, Maryland 20784-2926 32. Registrer's Signeture

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, end due to the ceuse(s) and menner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date and plece, and due to the cause(s) end menner steted.

License number

29d. Dete signed (Month, Day, Year)

3 AN . 4 2000 - 1 AAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene \(\Omega\) Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) January 11° 2000° **Physician** 3:00 P.M. Arthur Vernon Trefry /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, giva street and number) 4c. County of Death Examiner Prince George's Co. Clinton
If Under 24 Hrs. 5104 Salima Street 8. Date of Birth Dec. 8, 1910 7. Age (In yrs. last birthday) 89 Yrs. 5. Social Security Number 9. Birtholaca (State or Foreign **Funeral** Months Days Hours Min. Massachusetts 100M 20 F 012-16-3379 **Director** Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 1 Yes 2 No Maryland Prince George's Clinton notified Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with "natural", or items 23s or offices Examiner must be a 5104 Salima Street 20735 United States Pages 1 end 2 should be filed within 72 hours efter death nent of Health end Mentel Hygiene.
Instit if tem 27 is marked other than "natural", or itema 23 mir. If item traumatic avent, in a feeder Exam or man. Funeral 12. Was Decedent Evar in U.S. Armed Forcas? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puarto Ricen, etc.) 14. Race - American Indian. 11. Marital Status Black, Whita, atc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0020 1 Yas 2 No Specify Specify: White g 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) N/A Elementery/Secondary (0-12) 7th Welder General Electric 18. Mother's Name (First, Middle, Maiden Surnama) 17. Father's Name (First, Middle, Last) Vernon Trefry Mary Westhaver 19b. Malling Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Relationship (Type, Print) Robert A. Trefry (son) 5104 Salima Street, Clinton, Maryland 20735 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stata Important: If its any injury or oth Date 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Lee Crematory Jan. 12, 2000 Clinton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Lee Funeral Home, Inc. 6633 Old 21. Signature of Funeral Service Licensee Alexanderia Ferry Road, Clinton, Maryland 20735 23a. Part1. Enter the disease, or complications their caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Physician immediate Cause (Final disease or condition resulting in deeth) /Medical Examiner Examiner physicien end s the buriel-transit that the death certificate be executed Sequentially list conditions, if any, leading to Immadiete ceuse. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in death) Last Division of Vital Records, P.O. Box 68760, Physician/Medical 80 950 23b. Did tobacco use contribute to the cause of death? ed by the deteched Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown signed b þ 24b. Were autopsy findings svallable prior to 24a. Was an autopsy Completed completion of cause of death? The law certificate has b irector, pege 2 s 1 Yes 20 No t □ Yes 2E No or Attending Physician: Was case Merred to m Be 26. Place of Death (Check only one) To 1 Yes 2500 Other: 4 Nursing Home Assidence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 12 Trintural 5 Pending s efter des. 1 Yes 2 [] No investigation 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours eft Funeral Di letely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steled. 29a. Certifier edical stely ticel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated. (Check only one) within 2 To the 29d. Data signed (Month, Day, Year) 296. Signature and tall of conti 29c. Licansa number January 12, 2000 30. Name and address of person who completed ceuse of death (item 23a) (Type, Print) Rene E. Grace, MD 9131 Piscataway Road, Clinton, Maryland 20735

DHMH 16 Rev 6/95

Registrar

31. Date filad (Month, Day, Year)

JAN 1 3 2000

32. Registrar's Signature

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

| | | | Cei | rtificat | te of | Death | | Reg. No. | J () | C 000 | | | |
|--|---|---|------------------------|-------------------|-----------------|--|-------------------|--------------------------------|-------------------------------|-------------------------------------|--|--|--|
| 1. Decedent'a Name (First, Mid | fle, Last) | | | | | HOUSE LIFE | 2. Date of Do | ite of Death | | 3. Time of Death | | | |
| RONNYA L. | TAYLOR | | | | | | | y 10, 20 | | 1:21 AM | | | |
| 4a Facility Name (If not instituti | on, give street and numb | er) | 1111-3 | | | 4b. City, Town, or | | | | | | | |
| SHADY GR | OVE ADVEN | TIST | HOSPI | TAL | | ROCKVI | ILLE | MON | TGOME | ERY | | | |
| 5. Social Security Number | | Age (In yrs. | last birthday) | If Unde Months | 1 Year | | (Month D | rth av. Year) | 9. Birthpla | ice (State or Foreign | | | |
| 079-54-3957 | 1□ M 2□F | | 51 Yrs. | | - | | March | , 1948 | South | "CArolina | | | |
| Usual Residence of Decedent 10a. State 10b. Count | u. | 100 C# | y, Town or Lo | oation | | | | | 110 | d Incide City Limite | | | |
| | | | | | | | | | 100 | d. Inside City Limits 1X Yes 2 □ No | | | |
| Maryland Montg | omery | Roc | kville | - | | | | | | 12 11 22 21 22 | | | |
| 10e. Street and Number 7905 Capricorn | Torraco | | | 10t. Zij | Code | 20055 | | 10g. Citizen of N | | у? | | | |
| | | | | | | 20855 | | U.S.A | | | | | |
| 11. Marital Stetus | 12. Was Decede Armed Force | es? | 5. 13. | if Yes, spe | city Cub | Hispanic Origin? (an, Mexican, Pue | to Rican, etc.) | Blac | e - America: ck, White, et | | | | |
| 1 Never Married 2 Ma 3 Widowed 4 Divorce | If Yes Give | K No | | 1 🗆 Yes | 2K) No | Specify: | | Specify | Black | ζ | | | |
| 37-183 | nt'a Education | 98. | 16a. Dece | dont's Heu | al Ossia | netion | | 16b. Kind of B | uning and Andu | ietor | | | |
| (Specify only high | est grade completed) | | (Give | kind of wo | ork done | during most of wo | orking | TOO. KING OF D | usine sain ruc | istry | | | |
| Elementary/Secondary (0-12) | College (1-4 | or 5+) | Payro | | | , | | Nationa | 1 Cour | ncil of Ch | | | |
| 17. Father's Name (First, Middle | , Last) | | | | | 18. Mother's Na | me (First, Middle | , Maiden Suman | | | | | |
| Charlie Mose | | | | | | 01 | | | | | | | |
| 19a. Informant's Neme/Relation | | | 19b. Mailir | na Addres | s (Stree | t and Number or F | tine Lir | | State. Zio C | Code) | | | |
| Christine Thoma | | | | | | n Terr., | | | | | | | |
| 20a. Method of Disposition | io mother | 20b. F | Place of Dispo | sition (Na | me of | | Date | 20c. Location | 20855 City or Tow | - | | | |
| 1 Burial 2 Cremation | | 916 | cemetery, crer | | | | | | | | | | |
| 4 Donation 5 Other (| | Ro | ck Cre | | | | 1-14-00 | Washing | gton, | D.C. | | | |
| 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility Marshall's Funeral Home, Inc. | | | | | | | | | | | | | |
| Julia . | Marsh | all | | | | | | | D 207 | 46 | | | |
| 23a. Part Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate intervel Between Consett and Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate intervel Between Consett and Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate intervel Between Consett and Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate intervel Between Consett and Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate intervel Between Consett and Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate intervel Between Consett and Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate intervel Between Consett and Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate intervel Between Consett and Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate intervel Between Consett and Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate intervel Between Consett and Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate intervel Between Consett and Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate intervel Between Consett and Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate intervel Between Consett and Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate intervel Between Consett and Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate intervel Between Consett and Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate intervel Between Consett and Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate intervel Between Consett and Do not enter the mode of dying, such as cardiac or respi | | | | | | | | | | | | | |
| Lance Control (First | | | | | | | | | | Jiset and Death | | | |
| Immediate Causa (Final disease or condition resulting in death) | a Acute 1 | lyocar | dial I | nfarc | tio | n | | | m | inutes | | | |
| rooding ar obdary | Due to (or as a consequence of): | | | | | | | | | | | | |
| | у | ears | | | | | | | | | | | |
| Sequentially list conditions, if any, leading to immediate | Ity list conditions, Due to (or as a consequence of): | | | | | | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | C | C. Control (some some some some some some some some | | | | | | | | | | | |
| that initiated events resulting in death) Last | | r es a conseq | uence of): | | | | | | | | | | |
| | d | | | | | | | | | | | | |
| | | | 1 | | | | | | | | | | |
| Part II. Other algnificant condit | ons contributing to deat | h but not res | ulting in the u | nderlying o | cause gi | ven in Part I. | | | | the cause of death? | | | |
| | | | | | | | 1 | Yea 2 No | 3 Probe | ably 4∯Unknowr | | | |
| | | | | | | | 240 100 | s an autopsy | 24h Wer | e autopay lindings | | | |
| | | | | | | | perl | ormed? | avei | lable prior to | | | |
| | | | | | | | | | of de | eath? | | | |
| | | | | | | | 10 | Yes 21 No | 10 | Yes 2□ No | | | |
| 25. Was case referred to medic axaminer? | | | | | | | eath (Check only | one) | | | | | |
| 1 ☐ Yes 2 ☐ No | Hospital: 1 🗆 Inp | | ER/Outpatier | - | JA | | | idence 6 Oth | | | | | |
| 27. Manner of Death 1 Statural 5 ☐ Pend | 28a. Date of (Month, | njury Day Year) | 28b. Time of Injury | | 28c. Inju Wo | | 28d. Describe | how Injury occur | red | | | | |
| 2 Accident inves | igation not be | | | М | | Yes 2□No | | | | | | | |
| | nined 259. Place of | Injury - At he etc. (Specify | ome, farm, atr | eet, lactor | y, office | | | (Street and Numl wn, State) | ber or Rural | Route Number, | | | |
| | | | | | | | | | | | | | |
| | ng Physician: To the be Examiner: On the basi | | | | | | | | | | | | |
| anej | and manne | | | | | | | | | | | | |
| 29b. Signature and title-of certifi | 11 | | | 29 | | se number | | 29d. Date signe | | ay, rear) | | | |
| 120 | 1/2/ | 7.0 | | | D | 37024 | | Januar | y 10. | 2000 | | | |
| 30 Name and address of person | who completed cause | of death (Item | 23a) (Type, | Print) | | | | | 0 | | | | |
| David G. Si | our, M.D. | | 9901 1 | Medic | a1 (| CEnter Di | rive, Ro | ckville, | MD 2 | 0850 | | | |
| 31. Date filed (Month, Day, Year | 000 32. Reg | istrar's Signa | iture | | | - | | | | | | | |
| JANU 1 7 / | 1.17 (1) | | | | | | | | | | | | |

DHMH 16 Rev 6/95

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Tima of Death 2000 4c. County of Death Dorladeen Thomas 4b. City, Town, or Location of Daath 1:00P.M. 4a Facility Nama (If not institution, give street and number) 1121 Cherry Hill Rd Apt 303 Beltsville Prince Georges if Undar 24 Hrs. If Undar 1 Yaar 5. Social Sacurity Number 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplace (Stata or Foreign Country) Months Days Hours Min. 1□M 25 F 236 54 9056 Yrs. 63 Dec 9 1936 W.Va Usuai Rasidanca of Decedant 10b. County 10c. City, Town or Location 10d. inside City Limits Beltsville 1 XYas 2 □ No Prince Georges 10f. Zip Coda 10g. Citizen of What Country? 10e. Street and Number 11212 Cherry Hill Rd 22705 USA 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yes 2 ②No If Yes, Giva Yaar or Datas: Was Decedant of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian 11. Marital Status Black, Whita, atc. 1 Nevar Marriad 2 Married 1 ☐ Yas 2 ☑ No Specity: White 3 ☑ Widowed 4 □ Divorced 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Businass/Industry Elemantary/Secondary (0-12) Collega (1-4or 5+) Credit Bureau Clerk-Typist 18. Mothar's Nama (First, Middle, Maiden Sumama) 17. Fathar's Nama (First, Middla, Last) Mae Liller George H. Burdock 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Coda) 19a. Informant's Name/Ralationship (Type, Print) 11212 Cherry Hill Rd Teresa Thomas Beltsville, Md 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition Data 1 Surial 2 □ Cramation 3 □ Ramoval from Stata Kalbaugh Cemetery Jan 4 2000 Elk Garden W.Va 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Funaral Service Licenses 22. Nama and Addrass of Facility David A. Burddck FH 23a. Part. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiretory errest, shick, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Death Immediata Causa (Final disaasa or condition rasulting in daath) Sequantially list conditions, if eny, leeding to immadiata causa. Entar Undarlying Causa (Disaasa or Injury that initiated events rasulting in daath) Last 23b. Did tobacco use contribute to the cause of death? Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 12 Yes 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings available prior to complation of causa of daath? 24a. Wes an autopsy performed? 1 Yas 2/ No 1 ☐ Yas 2 ☐ No 26. Placa of Death (Check only one) Othar: 4 Nursing Homa 5 Rasidance 6 Other (Specify) 1 Inpatiant 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred 28e. Deta of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work?

Physician /Medical **Examiner**

Physician

/Medical

Examiner

10a. Stata

Md

12

Funeral

Director

r 28a-f show show

"naturel", or items 23s or solical Examiner must be

permit. Pages 1 and 2 should be filed within 72 hours after death to Department of Health and Mental Hygiena. Important: If fem 27 is marked other than "naturel", or frems 23s any injury or other treumatic event, the Medical

altimore, Maryland 21215-0020

Directo

Funeral

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Completed

Be

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physician and s the buriel-transit USB BS for signed t should I certificata has b director, this funeral

The law requires that the death certificete be executed

P.O. Box 68760.

Division of Vital Records,

or Attending Physician:

Hospitai

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Examiner Physician/Medical þ Completed Be To Certification: a Funeral Director: Aft bletely filled in by the fur

25. Was cesa referred to medical axaminar? 1 Yas 2 No 27. Menner of Deeth 5 Panding invastigation 1 ☐ Yas 2 ☐ No 2 Accidant 6 Could not be datarmined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicida 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 4 Homicide 29a. Cartifian

Certifying Phyeician: To tha best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. Licansa number

29d. Data signed (Month, Day, Year)

30. Nama and addrass of person who completed cause of deeth (Item 23a) (Type, Print)

1030 ONCE OR 31. Data filad (Month, Day, Year) 32. Registrar's Signatura JAN 2000 ▶

State Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Day 17 Month **Physician** Maynard Thompson Sr. 2000 Jan. 7:50 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 1 M 2 F Yrs. Director 214-16-7677 30, 1922 Maryland Usual Residence of Decedent death with the Manyland pernit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Haaith and Mental Hyglene. Important: if item 27 is marked other than "natural", or frems 23a or 28a-f show with injury or other traumatic event, the Medical Examina must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director Maryland Anne Arundel Annapolis 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 1167 Ramblewood Dr. 21401 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 11 Marital Status 1 Ø Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Merried Baitimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: P Specify: 3 ☐ Widowed 4 ☐ Divorced WITT White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Heavy Machine Mechanic U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Maurice Thompson Marion Renn 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Polk / Daughter 1206 Ramblewood Dr. Annapolis, Md. 21401 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Cemetery 01-22-00 Brentwood, Maryland 22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester Street Annapolis, Md. 21401 23a Fert 1. Enterthe discountries or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel disease or condition resulting in death) reno Examiner Due to (or es a consequence of) Examiner Myeloma attending physician and for use as the burlai-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for es a consequence of) Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 3 ☐ FTobebly 4 ☐ Unknown 1 Yes 2 No cerelly unscular þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy performed? page 2 211 No 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director, 25. Was case referred to medical examiner? 89 26. Place of Death (Check only one) To 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28d. Describe how injury occurred 28b. Time of Injury Certification: 28a. Date of Injury (Month, Day Year) 28c. Injury et Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier of person who completed cause/of death (Item 23a) (Type, Print), Annapalis, m. 21401 205 31. Date filed (Month 32. Régistrar's Signeture State

DHMH 16 Rev 6/95

Registrar

JAN 18 2001 Same & Santh

State Registrar

John D. Uai

Baitimore, Maryland 21215-0020

Box 68760,

Division of Vital Records, P.O.

31. Date filed (Month, Day, Year) JAN 1 1 2000

29b. Signeture and title of certifier

JOEL SEWCHAND MD,

118 LAGRANGE AVE, P.O. BOX 975, LAPLATA, MD 20646 32. Registrar's Signeture

el Jasohams M. D.P.C.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 16 Rev 6/95

29c. License number

D-29646

29d. Dete signed (Month, Dev. Year)

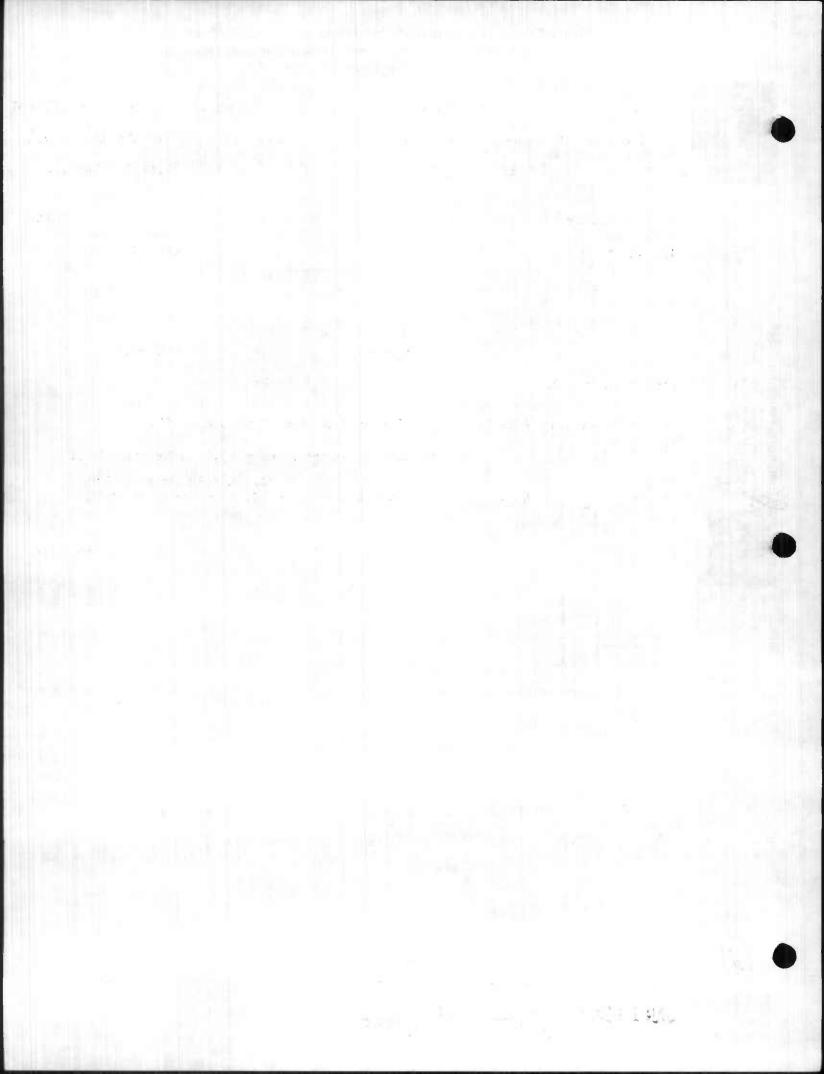
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 12. Date of Death

| | lama (First, Mide | dla, Last) | 4 | , , | , | | | | 2. Date of D Month | Day_ | 3. Time of D | | |
|--|--------------------------------------|-------------|--|---------------------|------------------------|------------|--|--------------------------------|--|--|--|--|--|
| | rene | | | lento | la | | | | Janua | ry 7, 2 | 2000 4:00 | | |
| | ne (If not institution | | reet and numb | | 1401 | | | 4b. City, Town, or | ure/ | | ce Georg | | |
| 5. Social Secur | aurel ty Number | 6. Sex | | - | last birthday) | If Under | | If Under 24 Hrs | | | | | |
| 579-36- Usual Residen | 8792 | 10 | M 27 F | | 5 Yrs. | Months | Days | Hours Min. | Februar | irth Pay, Year) Cy 23,19 | 9. Birthplaca (State or Country) 24 England | | |
| 10a. State | 10b. Count | ty | | 10c. Cit | y, Town or Loc | cation | | | | (A-1-10) | 10d. Inside City | | |
| Marylan | d Prince | e Geo | rges | Во | wie | | | | | | 1 □ Yes 1 | | |
| 10e. Street and | | | | | | 10f. Zip | | | | 10g. Citizen of | | | |
| | verton l | | | | | | 715 | | | Englan | | | |
| | us Marriad ŽAMa ed 4 □ Divorce | arried | 2. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No If Yes, Gree A Yaar or Dates: | | | | | an, Mexican, Puer Specify: | to Rican, atc.) | | ce - Amarican Indian, ck, White, etc. y: white | | |
| / | 15. Decede | ent's Educa | ation completed) | | 16e. Deced | ent's Usua | al Occup | pation during most of wo | orkina | 16b. Kind of B | lusiness/industry | | |
| | Secondary (0-12) | | College (1-4 | or 5+) | life. D | O NOT u | se retire | d) | | Orm U | Om o | | |
| 17 Father's Na | 12 me (First, Middle | a (ast) | | | Homema | aker | | | | | | | |
| Freder | | | | | | | 18. Mother's Name (First, Middle, Maiden Surnama) Phoebe Watts | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Routa Number, City or Town, S | | | | | | | | | | , Stata, Zip Code) | | | |
| Vincent | P. Ven | tola | / Husb | and | 4820 1 | River | ton | Lane B | owie, MI | 20715 | | | |
| 20a. Method of Disposition 20b. Placa of Disposition (Name of Competent Comp | | | | | | | | | | 20c. Location | - City or Town, Stata | | |
| Albunal 2 Cramation 3 Hemoval from Stata Ft. Lincoln Cemetery January 13,2000 Bren | | | | | | | | | | | twood, MD | | |
| Signature | f Funaral Service | e Licensee | Alebo | ×- | | | | ess of Facility Ft nsburg R | | | | | |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | |
| Immediate Cause (Final | | | | | | | | | | Onset and Death | | | |
| Immediate Cause (Final disease or condition resulting in death) Cardiac arrest | | | | | | | | | | moul | | | |
| Due to (or es a consequenca of): | | | | | | | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause Faller Underlying. Let 70.9 472. | | | | | | | | | | | | | |
| if any, leading cause. Enter | o immadiete Inderlying | | | HY | | | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events secutions in death) Lest. Due to (or as a consequence of): | | | | | | | | | | | | | |
| Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): d | | | | | | | | | | | | | |
| | | | | | | | | | | | | | |
| Part II. Other e | gniffcant condit | tions contr | ributing to death but not resulting in the underlying causa given in Part I. | | | | | | | 23b. Did tobacco use contribute to the cause of deat 1 Yes 2 No 35 Probably 4 Unknown | | | |
| CC | PD | | | | | | | | 1 | Yee 2 No | 3¥ Probably 4□ U | | |
| PI | D | | | | | | | | | s an autopsy | 24b. Were autopsy fin available prior to | | |
| - | 2 | | | | | | | | | formed? | completion of ca of death? | | |
| | | | | | | | | | 1□ | Yes 2 No | 1□Yes 201 | | |
| 25. Was case examiner? | eferred to medic | al | | | | | | 26. Place of De | ath (Check only | one) | | | |
| 25. Was case examiner? | 2DNo | Ho | spital: 1 Sinp | atient 2 | ER/Outpatient | | JA | | Home 5 Res | sidenca 6 □Ott | her (Specify) | | |
| 27. Mannar of | 5 Pend | | 28a. Dete of (Month, | Injury Day Year) | 28b. Time of Injury | | 28c. Inju Wo | | 28d. Describe | e how injury occur | rred | | |
| 1 Senatural 5 Pending Investigation 2 Accident 3 Suicide 4 Homicide 6 Could not be determined 1 Senatural 2 Senatural 2 Senatural 2 Senatural 2 Senatural 3 Suicide 4 Homicide 1 Senatural 2 Senatural 3 Senatural 2 Senatural 3 Senatural | | | | | | | | Yes 2 No | □ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 2 Accide 3 Suicid 4 Homic | | | | | | | | | | | | | |
| | 10 Certify | | ar: On the besi | r stated. | | | | | | | | | |
| 29a. Certifier (Check onlone) | 10 Certify | al Examina | | r stated. | | 29 | | sa number | | 29d. Date signs | ned (Month, Day, Year) | | |
| 29a. Certifier (Check onlone) | 10 Certifyi 2 Medica | al Examina | | r stated. | | 29 | | 5 3 411 | | 29d. Date signs | u o | | |
| 2 Accide 3 Suicid 4 Homic 29a. Certifier (Check onione) 29b. Signature | 10 Certifyi 2 Medica | ier (| and manner | mD | n 23a) (Type, F | | | 53411 | onie | Janus | u o | | |

DHMH 16 Rav 6/95



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State of Maryland / Department of Health and Mental Hygiene 0 24 14

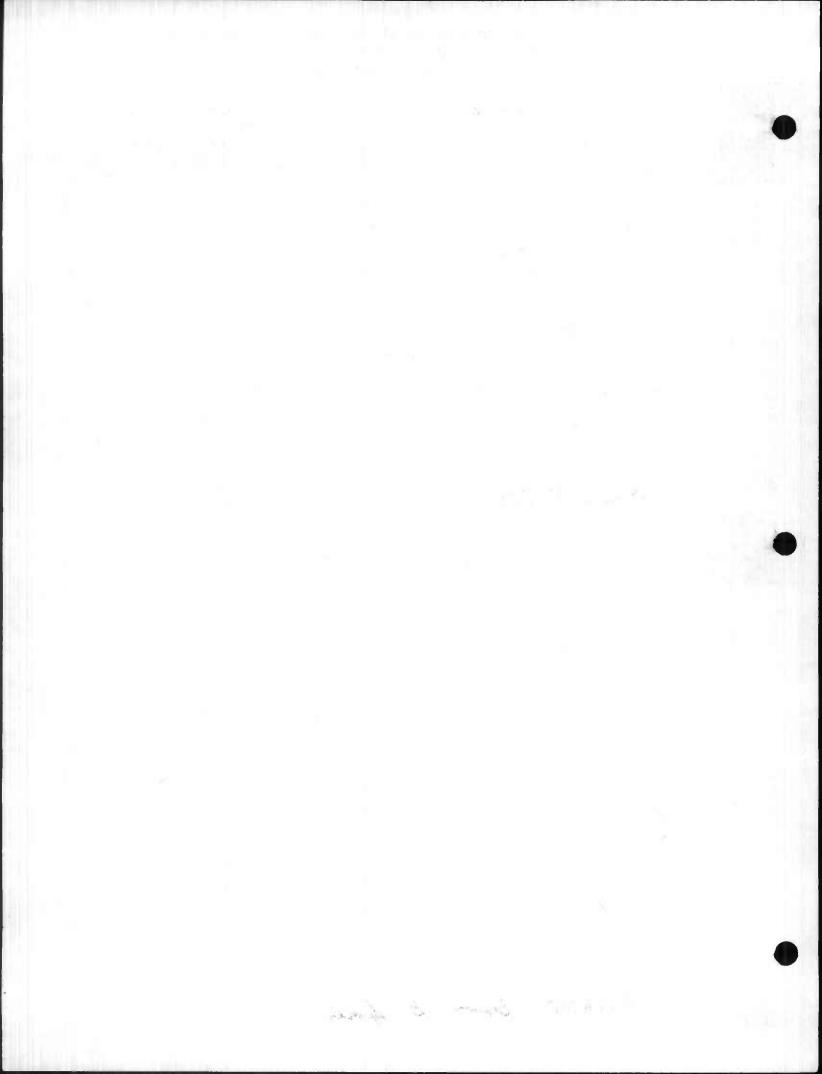
| | | | | | Certifica | ate of | Death | | Reg. No. | 0 0 | las I | | |
|---|--------------------|--|---|------------------------|--------------------------------------|--|---|---|------------------------------|--|--|------------|--|
| Division | N I | 1. Decedent's Name (First, Middla, La: | | | | | | 2. Data of D | eath | Vess | 3. Time | of Death | |
| Physici /Medic | | Robert Tha | mas Vallandin | gham | | | | Jan 1 | 3, Day | 2000 | 5:35 | AM | |
| Examir | | 4e. Fecility Neme (If not Institution, give | street and number) | | | | 4b. City, Town, or | Location of Dee | th 4c. Co | ounty of Death | | - | |
| | all 3 | Heritage Harbour He | ealth and Rehabi | litati | ion Ctr. | | Annapo | olis | An | ine Arund | iel | | |
| Funeral Director | | 5. Social Security Number 6. S 215–07–3321 | ax ☐ M 2☐ F 7. Age (in yi | | Yrs. If Unc Month | der 1 Year S Days | Hours Min | | rth ay, Year) ', 1910 | 9. Birth Cou | piaca (Statentry) aryland | e or Forei | |
| - M | | 10a. Stata 10b. County | 10c. | City, Town | or Location | | | | | | 10d. Inside | City Limi | |
| Man I | tor | Maryland Queen Anne | es | Stev | vensville | 9 | | | | | 1 ☐ Yes 2 📉 N | | |
| th with the Mai 23a or 28a-f s at be nothled | | 10e. Street and Number 301 Talbot Rd. | | 10f. Zip Coda 21666 | | | | | | of What Cou | | | |
| permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Heelih and Mentel Hydiene. Department of Heelih and Mentel Hydiene. Important: If them 27 is marked other than "natural", or itema 23a or 28a-f show many injury or other traumatic event, the Modical Evantual must be nothed at once. | by Funeral | 11. Marital Status 1 □ Navar Married 2 □ Married ③□ Widowed 4 □ Divorced | 12. Was Decedant Evar In Armed Forces? 1 ☐ Yes 2 ☐ No If Yas, Giva Yaar or Datas: | U,S. | | cedant of I pecify Cub 2 🗓 No | Hispanic Origin? (Sen, Mexican, Puer Specify: | Specify Yas or N to Rican, etc.) | | 14. Race - Americ Bleck, White, Specify: Whi | | | |
| natur fical | ted | 15. Decedant's Ed (Specify only highast gra | ucation | 16a. | Decedent's Us | ecedent's Usuei Occupation ive kind of work dona during most of a | | ndrina | 16b. Kind | of Business/Ir | ndustry | | |
| d within giene. rr than "r | Completed | Elementary/Secondary (0-12) | Collega (1-4or 5+) | | illa. DO NOT | usa retire | retired) | | | t Buildi | ing | | |
| Hy off | BeC | 17. Fathar's Name (First, Middla, Last) | | | - | | 18. Mothar's Na | ma (First, Middle | a, Ma <i>id</i> an Su | mama) | | | |
| ked o | To B | Joseph L. Valland | lingham | | | | Ida | a Matting] | _y | | | | |
| and Men | - | 19a. Informant's Name/Ralationship (7 | | 19b. | Mailing Addre | ss (Street | and Number or R | | | own, State, Zi | p Code) | | |
| and 2 eelth a n 27 is er trau | | Debbie A. Businsky/ | Daughter | | _ | | . Stevensv | | - | | | | |
| Pages 1 a ent of Hee nt: If Nem ry or othe | | 20a. Mathod of Disposition 1 ↑ Burial 2 ☐ Cramation 3 4 ☐ Donation 5 ☐ Othar (Specify | Ramovei from State | cematar | Disposition (A y, cramatory o | r other ple | 1 | Data 01-07-00 | | tion - City or T | | | |
| permit. Pages Department of I Important: If ite any injury or of once. | | 21. Signatura of Funeral Service Licen | | John M. Ta | ylor Fu | meral Ho | me, In | | | | | | |
| | | 23a. Part1. Enter tha disaase, or comp shock, or haart failure. List only | pilcations that caused the | eth. Dor | + | | | | | OLIS, FL | Approxim | nata | |
| hysician /Medical Examiner | er | Immadiata Causa (Final disaasa or condition rasulting in death) | a Adu | un | Led consequence of | 1)- | emens | | | | Intarval B Onset an | | |
| deau centificate be backing. e attending physician and ed for use as the buriel-transit | n/Medical Examiner | Sequentieily list conditions, if any, laading to immediata causa. Entar Undarlying Causa (Disaase or injury that initiated evants rasulting in death) Last | b. Due to (or es a consequence of): C. Due to (or as a consequence of): d | | | | | | | | | | |
| d for | cla | Part II. Other aignificant conditions or | entributing to dooth but not re | a authla a i a | the underlying | | von in Rost I | 22h Did | Itahaana | e contribute t | a Aba asus | a of dead | |
| | y Physician | rath. Other aignitions conditions of | sittleuting to death but not it | asulting in | tha underlying | g causa gr | van in Part i. | | Yes 2 | 1 | bably 4 | | |
| bould | Completed by | | | | | | | 24a. Was | s an autopsy ormed? | CC | /ere autops vailable pric ompletion of death? | or to | |
| ate hes b | E | | | | | | | 10 | Yas 2 1 | No 1 | ☐ Yas 2 | □No | |
| | Be | 25. Was casa referred to medical | | | | | 28. Placa of De | eth (Check only | ona) | | - | _ | |
| 0.0 | 10 | axaminer? 1 ☐ Yas 2 ☑ No | Hospital: 1 Inpatiant 2 | □ ER/Ou | tpetient 3 | DOA Ot | har: 4 Nursing I | | | Othar (Speci | ify) | | |
| in the same | | 27. Manner of Death 1 Natural 5 Panding 2 Accidant investigation | 28a. Date of Injury (Month, Day Year) | | | 28c. Inju Wo | | y Home 5 ☐ Residance 8 ☐ Othar (Specify) 28d. Dascribe how Injury occurred | | | | | |
| within 24 hours effer death. To the Funeral Director: After completely filled in by the fune | Certification: | 3 Suicida 6 Could not be datamined | 28e. Piaca of Injury - At building, atc. (Spec | homa, fe | rm, straat, fact | ory, offica | | 28f. Location City or To | (Street and town, Stata) | lumber or Run | al Roufa N | ımber, | |
| within 24 hours effe To the Funeral Dir completely filled in | edica | 29a. Certifier 1 | raician: To the best of my ki iner. On the basis of axami mennar stated. | nowledge nation and | , deeth occurre I/or Investigetic | ed at tha ti on, in my o | me, date end plece opinion, daath occu | e, end due to the urred at tha tima | cause(s) an , data and pl | d mannar as a ece, and dua t | stated. to the cause | a(s) | |
| within 2 To the comple | Me | 29ti. Signature and title of certile) | m.D. | | 2 | 9c. Licens | se number 8 | | | ilgned (Month, | | | |
| | | 30. Name and addrass of parson what | completed causa of daath (It | em 23a) (| Type, Print) | 300 | 21 Ho | SPIGA | / N/ | che | RIV | M./ | |
| | | 31. Deta filed (Month, Day, Year) | 32. Registrer's Sig | DOLLING. | J. | /- | , ,, | - 0 | , , , , , | CALID | 2 02 | 0- | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Date of Deeth 3. Time of Death **Physician** Month Donald \mathbf{E} Westfall Jan 16 2000 /Medical 8:06AM 4a. Facility Name (If not Institution, giva straet end number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Cumber land

If Under 24 Hrs.
Hours Min.
FEB 8 1935 Memorial Hospital Allegany If Under 1 Year Birthplace (State or Foreign Country)
 W • VA • 5. Social Security Number 7. Age (In yrs. lest birthday) **Funeral** Days 1 M 2 F Yrs 218-30-0558 64 Director Usual Residence of Decedent the Marylend 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumetic event, its Medical Examinar must be notified at 1 Yes 2 No Director MARYLAND ALLEGANY CUMBERLAND 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 451 NORTH CENTRE STREET 21502 U.S.A. Funerai 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuban, Mexican, Puerto Rican, atc.) 2 should be filled within 72 hours after n and Mental Hygiena. 1 Naver Married 2 Married ty Yes 2 □ No If Yes, Give Baltimore, Maryland 21215-0020 r Yes, Give Year or Dates:1956-1958 1□ Yas 2√2 No by Specify: WHITE 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest greda complated) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 CUSTODIAN CENTRAL Y.M.C.A. 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be ARTHUR CHARLES WESTFALL SR. ALVINA SHINGLEDECKER 19a. tnforment's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Heelth and important: If item 27 is n any injury or other traun CAROLYN WESTFALL WIFE 451 NORTH CENTRE STREET CUMBERLAND MARYLAND 21502 20a. Method of Disposition 20b. Place of Disposition (Neme of camatery, crametory or other place) 20c. Location - City or Town, State RFD FLINTSTONE 1 Burial 2 □ Cramation 3 □ Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) ROCKY GAP VETERANS CEMETERY JAN 19 2000 MARYLAND 22. Name end Address of Facility MERRITT ADAMS FUNERAL HOME P.A. endo 404 DECATUR STREET CUMBERLAND MARYLAND d. 23a. Part1. Enter the diseasa, or comshock, or heart failure. List only Approximate Interval Between Onsat and Death blications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest **Physician** tmmediate Ceuse (Final disease or condition resulting In death) /Medical a Arteriosclertic heart disease Examiner Uk yrs Due to (or es e consequence of): Examiner buriel-transit Sequantielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last pue Due to (or es e consequence of): physician s the buriel Box 68760. Physician/Medical Due to (or as e consequenca of): PO Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? the Yes 2 No 3 Probably 4 Unknown Chronic obstructive pulmonary disease Records. þ 24b. Were autopsy findings available prior to complation of cause of death? Completed 24a. Was en eutopsy 1 TYes 2 No Division of Vital 25. Was case referred to medical examiner?
15 Yes 2□ No Be 26. Piece of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 3 DOA 28e. Dete of Injury (Month, Dey Year) funeral 27. Manner of Deeth 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred i or Attending Fafter death. Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Placa of Injury - At home, ferm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 24 hours a Funeral 29a. Certifie 1 _certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and menner as stated. (Check only Madical Examinar: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. To the To the To the 29d. Date signed (Month, Dey, Year) 29b. Signature, 29c. Licansa number Dpty Med Ex 5 D 09157 Jan 16 2000 30. Neme and autress of person who completed cause of death (Item 23a) (Type, Print) This 124 w 3rd st Cumb 11d 21502 Snow, M.D. 32 Registrar's Signature State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Elizabeth Wilson 36 January 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, 4c. County of Death 7. Age (In yrs. last birthday) 7. Yrs. 92 Yrs. Months [lambridge Dorchester Dorchester General 5. Social Security Number Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex Birthplece (State or Foreign Country) 1 □ M 208 F 220-01-228 Usuel Residence of Decedent Days July 22,1907 Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 242 No orchester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5418-Rhode dale-Vienna USA 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes 2 PNo If Yes, Give Year or Detes: 11. Marital Stetus Raca - American Indian, Black, White, etc. 1 Never Merried 2 Married 1□ Yes 212 No Specify: 3 Widowed 4 □ Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Housewife Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) hester William 4nnie 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) -rances Williams 1005 Maces Lane Cambridge, Maryland 21613 20b. Piace of Disposition (Name of cemetery, crematory or other piece) Location - City or Town, State 20a. Method of Disposition Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 1/21/2000 Ceneteri 4 Donation 5 Other (Specify) Chester Vienna Maryland 22. Name and Address of Facility Henry Funeral 21. Signeture of Funeral Servica Licensee Henry 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, 39 Approximate Approximate C Thrombosis Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequenca of) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings evailable prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 No 1 Yes 2 No 26. Piece of Death (Check only one) Hospital:

/Medicai Examiner or Attending Physician: The law requires thet the death certificete be asscuted for use as the buriel-trens P.O. Box 68760, sate has been signed by page 2 should be detact Division of Vital Records,

certificate

this funeral

After

daath.

To the Hospital o within 24 hours aff To the Funeral Di completely filled in

director.

Physician

/Medicai

Examiner

Funeral Director

Completed by

Be

Funerai

Director

show

28a-f

Berra 23a or

'natural', or

al Hygiene.

is marked

Important: If Item 27 I any injury or other to

Pages 1 and 2 should be nent of Health and Mental

Department of

Physician

the Medical Examiner

filed within 72 hours after

Baltimore, Maryland 21215-0020

Physician/Medical Examiner à Completed Be Medical Certification: To ours after death.

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? 1 Naturel
2 Accident 5 Pending investigation 1 Yes 2 No 3 Sulcide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

29a. Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

empleted cause of death (Item 23e) (Type, Print)

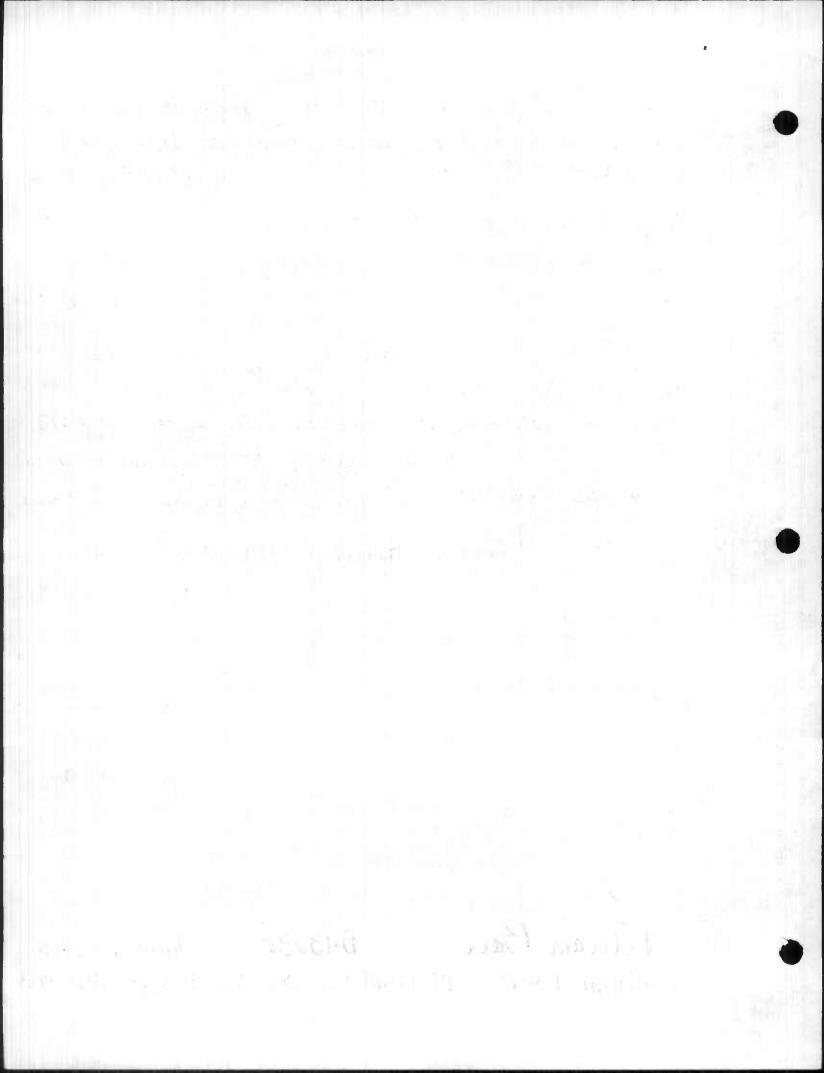
29c. License number

29d. Date signed (Month, Day, Year)

Cambridge,

State Registrar

19 32. Registrar's Signature JAN 1 8 2000



Baltimore, Maryland 21215-0020

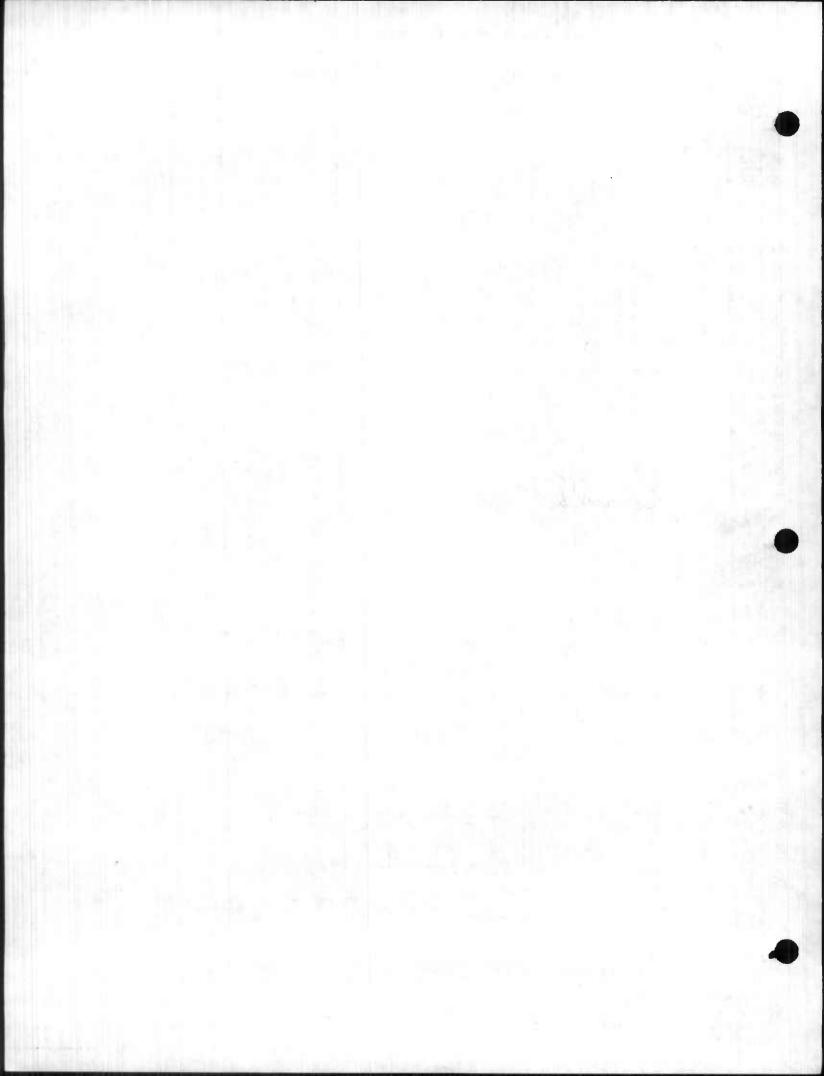
Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

| | 1. | 5: #23 P | | | 178 | | | | 7/0 | | | 2. Date of De | ath | | | 3. Time of Death |
|---|-----------|--|--|------------------------------|--|--|---|---|--|---|-----------------|--|---|-------------------------------------|--|--|
| sician edical | Ľ | TAMMY I | YNN WII | LIAMS | | | | | | | | JANUA: | RY 15 | , 200 | | 0600 AM |
| miner | 48 | Facility Name (| (If not institution NDIAN TO | | | | | | | 4b. City, To RODES | | ocation of Death | | ounty of De | | |
| ral or | | Social Security P | 655 | 6. Sex 1 □ M 2€ | | | last birth | Months | ler 1 Yeer s Deys | If Under Hours | 24 Hrs. Min. | 8. Dete of Bir (Month, Da OCT • 12 | th ly. Year) 1,1964 | 9. B | irthpia Country RYL/ | ce (Stete or Fore AND |
| * | 10 | sual Residence d Da. State ARYLAND | 10b. County DORCHE | omen. | | | | or Location | | | | | | | 100 | d. Inside City Lim |
| uneral Director | | Oe. Street and Nu | | DIEK | | KHU | DESD | | Zip Code | | | | 10g. Citizer | n of What (| Countr | y? |
| O le | 1 | 5538 IND | DIANTOWN | ROAD | | | | | 216 | 559 | | | | USA | | |
| by Funeral | 11 | 1. Marital Status 1 Never Men 3 Widowed | ried 2 Merri | ed 1 If Ye | Decedent ed Forces? Yes 2 21 es, Give r or Detes: | | ,s. | | | dispanic Ori an, Mexicar Specify: | | pecify Yes or No Rican, etc.) | | . Raca - Ar Black, Wi becify: | hite, et | |
| Completed | | | 15. Decedent acify only highes | t grade compl | | | 16a. C | Decedent's Us Give kind of w life. DO NOT | sual Occup vork done use retire | pation during mos | t of work | king | 16b. Kind EXHIE | of Busines | ss/Indu | istry |
| Comp | L | Elementary/Sec. | | | ege (1-4or 5 | 0+) | | PENTER | INTER | | | | | RUCT | ION | |
| Be | 17 | 7. Father's Name | | | CD | | | | | | | ame (First, Middle, Maiden Sumeme) | | | | |
| 5 | - | BERNARD | | | | | 105 | Anilina Addes | se /Chart | | | JO SAHNO | | 'nun State | 7in C | Code) |
| | | 9a. Informant's N ERNARD E | | | | ATHE | | | | | | | | | | |
| | - | Da. Method of Dis | | Timio, | DR. / 17 | | A | Disposition (N | | WIN IKO | , سما | Date | | tion - City | | |
| 7 | 1 | 1. Signatural of F | 0 | 13- | Sall | 11 | | ZELLEI | R FIIN | IF.RAT. | HOMI | P O | BOY | 207. | | |
| an al | - | | the disea of or ent failure | complications only one cause | | | ALCO | 106 Ma of enter the mo | AIN S ode of dyir | TREET ng, such es NE AN | cardiac | AST NEW or respiratory a | MARKE rrest, | | 1 | |
| al er | In d | mmediate Ceuse lisease or condities esulting in death) | the disease, or en failure List (Final on | complications only one cause | | INED | ALCO | 106 Ma | AIN S ode of dyin CODEI ATION | TREET ng, such es NE AN | cardiac | AST NEW or respiratory a | MARKE rrest, | | 1 | |
| edical Examiner | In d re | mmediate Ceuse lisease or condition | the disease of entitle that the disease of the conditions, mmediate lerying r injury ts | a b d | COMB | Due to (d | ALCO IN or es e co | 106 MA of enter the mo OHOL, O VTOXICA | AIN S ode of dyin CODEI ATION f): | TREET ng, such es NE AN | cardiac | AST NEW or respiratory a | MARKE rrest, | | 1 | Approximate nterval Between |
| a paraminer lan/Medical Examiner | In d re | mmediate Ceuse lisease or conditi- esulting in death) dequentially list or any, leading to in ause. Enter Und ause (Disease or nat Initiated event esulting in death) | the disease of erifailure Last (Final on onditions, mmediate eriying r injury is Last | a b c | COMB | Due to (c | ALCO IN or es e co or as a co | 106 MA of enter the mo OHOL, O TOXICA onsequence of | AIN S ode of dyin CODEI ATION (1): | STREET ng, such es NE AN | cardiac | AST NEW or respiratory a | MARKE (rest, DRUG | ET, MI | | Approximate nterval Between Onset and Death |
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State Registrar 31. Date filed (Month, Dey, Year)

JAN 18 2000



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Dey Month KENNETH LEE WAGNER 13, 2000 10:45 PM JAN. 4a Facility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death 2016 RIDGE RD. WESTMINSTER CARROLL If Under 1 Yeer If Under 24 Hrs. 8. Dete of Birth Months Devs Hours Min. (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) 1 M 2 □ F Yrs 53 1946 MARYLAND 216-44-2418 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10e. Stete 10b. County 1 ☐ Yas 2 No CARROLL WESTMINSTER 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2016 RIDGE RD. 21157 USA. 12. Wes Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - American Indien, Bleck, White, etc. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 11 Marital Status 1 ☐ Never Married 2 ☐ Merried Specify: WHITE 3 Widowed 4 Divorced Yeer or Detes: 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use ratired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 RAIL BUILDER MANUFACTURING 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) HERMAN WAGNER GERTRUDE ESTELLE YINGLING 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 28016 19a. Informant's Neme/Relationship (Type, Print) JUNE L. WAGNER - EXWIFE 302 E. LOUISIANA Ave., Bessemer City, NC. 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, State 1 Buriel 2 □ Cremetion 3 □ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) WESTMINSTER CEMETERY1/17/2000 WESTMINSTER, MD. 22. Name and Address of Fecility FLETCHER FUNERAL HOME 21. Signeture of Fuperal Service Licenses 254 E. MAIN ST., WESTMINSTER, MD. 21157 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Deeth Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Due to (or es e consequence of): Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 1 Yes No 3 Probably 4 Unknown

Physician /Medical Examiner

permit. Pagas 1 and 2 should be filt Department of Haatth and Mental by Important: If Item 27 is marked oth eny fulury or other traumatic event paga.

Physician

/Medical

Examiner

Funeral

Director

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r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

be filed within 72 hours after death which hydrone.

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The law requires that the death certificate be assecuted

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To the Hospital o within 24 hours af To the Funeral Di completaly filled in

Division of Vital Records, P.O. Box 68760,

Physician/Medical Examiner

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Certification:

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Sequentielly list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initiated events resulting In death) Last

25. Wes cese referred to medicel

examiner?

1 Yes 2 No

27. Manner of Deeth
Naturel
2 Accident

3 Suicide

29a. Certifier

4 Homicide

24e. Wes en eutopsy performed?

24b. Were eutopsy findings eveileble prior to completion of ceuse of deeth?

1 ☐ Yes 2 ☐ No

28. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how Injury occurred

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one) 29b. Signeture end title of certifier

5 Pending investigation

6 Could not be determined

1 Certifying Phyelcien: To the best of my knowledge, deeth occurred at the time, dete end plece, end due to the ceuse(s) and menner as steted.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the ceuse(s) end menner stated. 29c. License number 29d. Date eigned (Month, Day, Year)

28e. Dete of Injury (Month, Day Year)

30. Neme and eddress of person who completed ceuse of death (Item 23a) (Type, Print) DAVID A VAN E- NOIND 22 S Greene St B- Himore, Md 21791

State Registrar

31. Dete filed (Month, Day, Year)

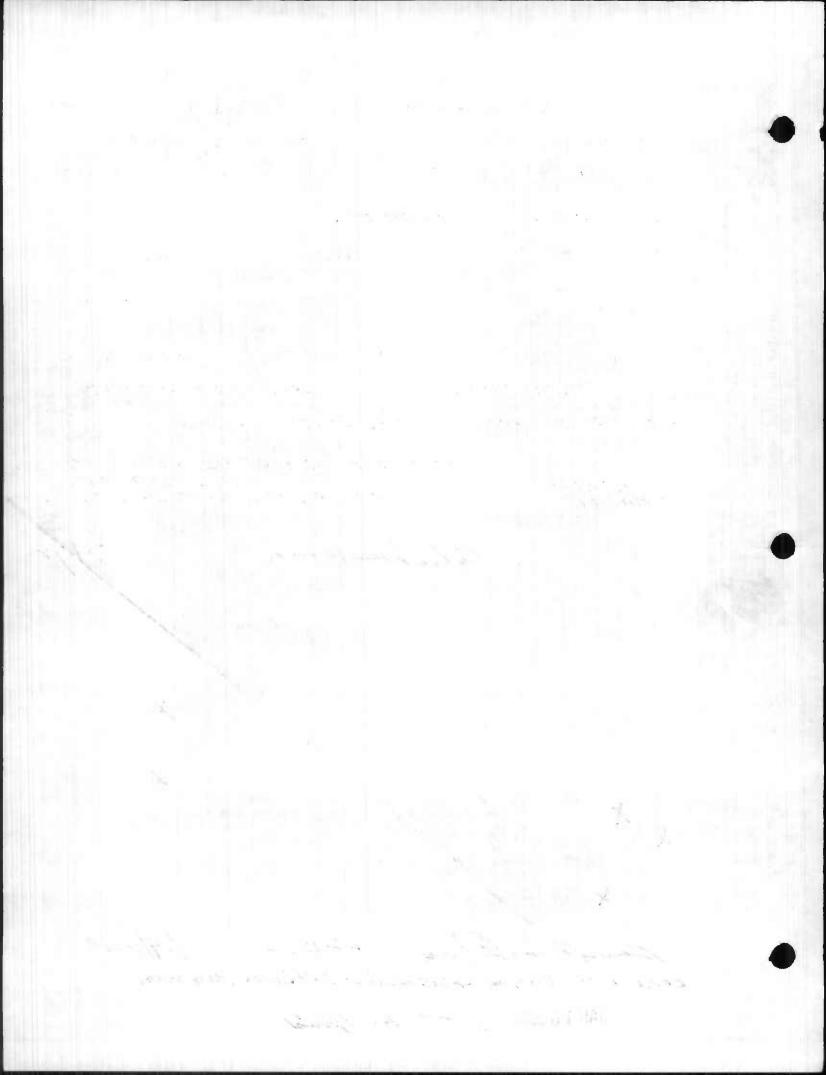
32. Registrar's Signeture

JAN 18 2000



Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tims of Death Day Month Year **Physician** MAKIE WALTER 7.45 PM OAN 11, 2000 4c. County of Death January 2000 /Medical 4a Fscility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE CITY JOHNS HOPKINS HOSPITAL 8. Date of Birth (Month, Day, Year) Feb. 15, 1934 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral Days Hours Months 1 □ M 2 Ø F 215-30-1327 65 Maryland Director **Usust Residence of Decedent** 10b. County 10a. State 10d. Inside City Limits 10c. City, Town or Location Carroll Sykesville 1 ☐ Yes 2 No Director 10e Street and Number 10f. Zip Code 10a, Citizen of What Country? 21784 USA 7066 Saddle Drive Funeral 14. Race - American Indien, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U,S. Armed Forces? 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hyglene. Important: If Nem 27 is marked other than "natural; or her any Injury or other traumatic event, tre Medical Experiment Yes 21 No 1 Never Married 2 Married 1 Yes 2 No Specify: White Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Education Teachers Assistant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Eleanor A. Roeder Henry M. Miller 19b. Msiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7066 Saddle Drive Sykesville, MD 21784 19a. Informant's Name/Relationship (Type, Print) Mr. Martin O. Walter (Husband) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Deurial 2 Cremation 3 Removal from State 1/15/2000 Baltimore, MD Loudon Park Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility HOME & CHAPEL (Box 195) man Sykesville, MD 21784 (410)-795-1400 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cade on each line. Approximate IntervsI Between Onset and Death **Physician** Immediats Cause (Final disease or condition resulting in death) /Medical LEFT FRONTAL LORE GLIOBLASTOMA MULTIFORME Examiner Due to (or as a consequence of) Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 1 Whitenown OBSTRUCTIVE PULL MONARY Completed by 24b. Were eutopsy findings sysilable prior to 24a. Was an autopsy performed? completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? edical Certification: To Be 26. Place of Death (Check only one) Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Manner of Death 1 PNaturat 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury al Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

attending physician and for use as the burial-transit The law requires that the death certificate be executed Box 68760. P.O. of Vital Records, certificate has To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica funeral Division

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Maryland

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then "natural", or flame to

3 ☐ Suicide 4 | Homicide

(Check only one)

29b. Signature and title of certifier

29a. Certifier

6 Could not be

28e. Place of Injury - At home, farm, street, fsctory, office building, etc. (Specify)

RES - 000

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as atsted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

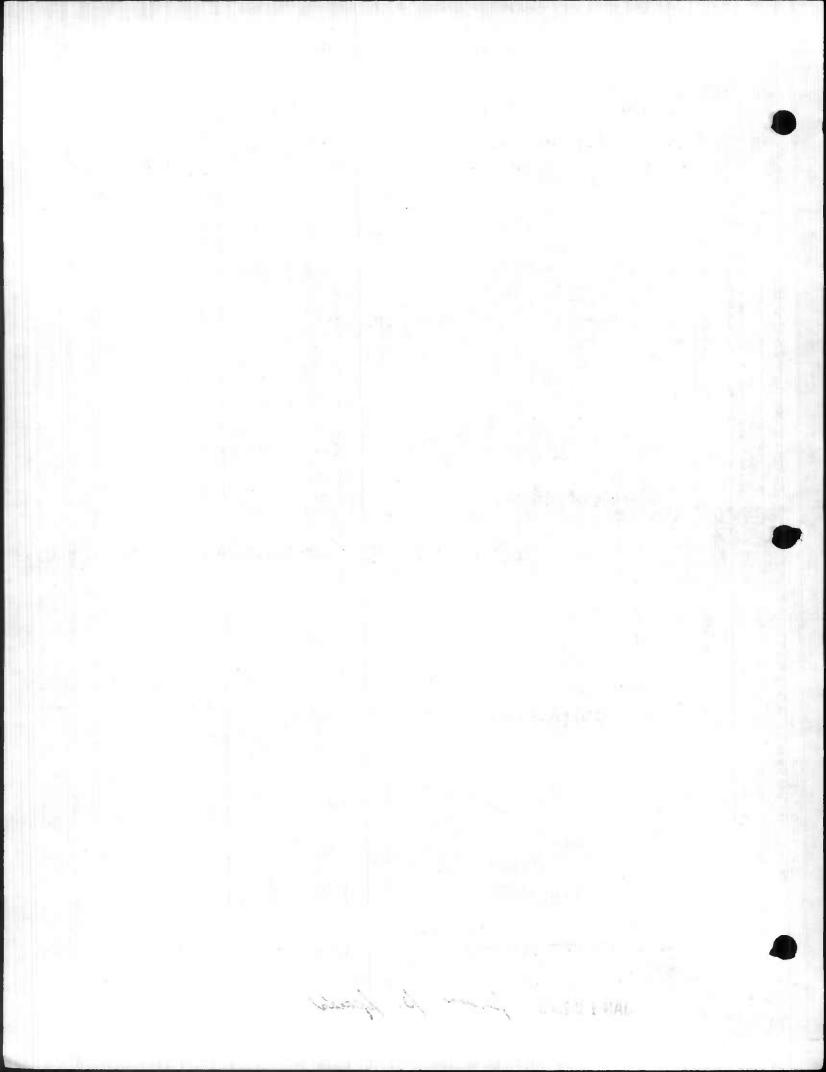
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

INTERN

301 North CAROLINE STREET Baltimure Maryland

State Registrar

KEYHANI



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 02120 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Tima of Death Day Month Year VIUENSCHEL 11:30 AM NORMA 11 2000 JANUARY 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death RANDALLSTOUN BALTIMORE NORTHWEST HOSPITAL CENTER 7. Age (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. Birthplace (State or Foreign Country) Md 8. Date of Birth (Month, Day, Year) NOV 16, 1923 5. Sociel Security Number 6. Sex 218-14-1426 10 M 20 F Usual Residence of Decedent 10a. Stete Md 10c. City, Town or Location Randallstown 10d. Inside City Limits Baltimore 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21133 3452 Carriage Hill Circle USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Merital Status 12. Was Decedent Ever in U,S. Armed Forces? 14. Rece - American Indian. Bleck, White, etc. 1 Yes 2 No 1 Never Merried 2 Merried 1 ☐ Yes 20 No Specify: Specify. White 3√2 Widowed 4 □ Divorced Yeer or Detes: 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) clerk banking 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumame) Matilda Bright Joseph Edwin Dean 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5070 Amantea Way, Sykesville, Md 21784 John E. Wuenschel (son) 20a. Method of Disposition 20b. Plece of Disposition (Name of 20c. Location - City or Town, State 1 Denovel from State Lake View Memorial 1-14-2000 Sykesville, Md 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Facility 21. Signeture of Funeral Service Licensee Haight Funeral Home & Chapel Paige Haight Herbert P.O. Box 195 Sykesville, Md 21784 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Death Immediate Cause (Final disease or condition resulting In death) PNEUMONIA Due to (or as a consequence of): Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last Due to (or es a consequence of): Due to (or es a consequence of):

Physician /Medical Examiner

an/Medicai Examiner

Physician

/Medical

Examiner

Funeral

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or Herre 23a or arrither must be

Pages 1 and 2 about be filed within 72 hours after earl of Health and Medral Hydjanu.

Intil Ren 37 is reacted other than "natural; or he way or other traumetic event, the Medical Examine any or other traumetic event, the Medical Examine

Baltimore, Maryland 21215-0020

Director

Funeral

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Be Completed

The lew requires that the deeth certificate be executed Division of Vital Records, P.O. Box 68760, signed by the at To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, I

| Pert II. Other significant conditions | | sulting in the underlying | cause given in Part I. | 23b. Did tobacco use c | ontribute to the cause of death? 3 Probably 4 Unknown |
|--|--|-----------------------------|---------------------------------|--|---|
| HYPERTE | NOIZM | | | 24e. Wes en eutopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
| 25. Was case referred to medical | | | 26. Place of D | eeth (Check only one) | |
| axaminer? 1 Yes 2 No | Hospitel: 1 Inpatient 2 | ☐ ER/Outpatient 3☐ D | OA Other: 4 Nursing | Home 5 ☐ Residence 8 ☐ O | ther (Specify) |
| 27. Manner of Death 1 Neturel 5 Panding 2 Accident investigetic | 28a. Dete of Injury (Month, Dey Year) | 28b. Time of Injury M | 28c. Injury at Work? 1 Yes 2 No | 28d. Describe how injury occu | urred |
| 3 Suicide 6 Could not determined | | nome, ferm, street, fecto | ry, office | 281. Location (Street and Num City or Town, Stete) | nber or Rural Route Number, |
| | | | | ce, end due to the cause(s) end moured at the time, date and place | |
| 29b. Signature and title of certifier | | 29 | 9c. License number | 29d. Date sign | ed (Month, Day, Year) |

State Registrar

31. Dete filed (Month, Dey, Year)
JAN 1 2 2000 32 Registrer's Signeture

K.S.RAO.MO

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) 1 C. S. R. A.O. M. O.

NORTHWEST HOSPITAL CENTER RANIDALLSTOWN

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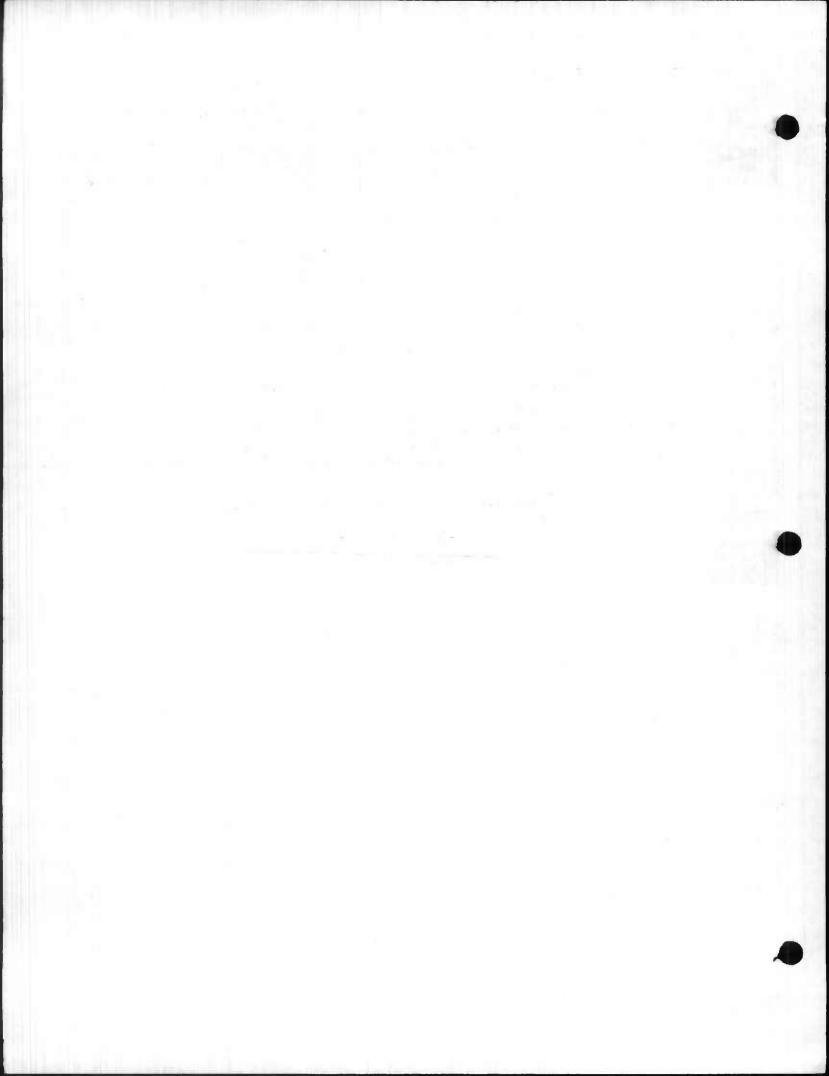
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State of Maryland / Department of Health and Mental Hygiene 11 12 12

| Dhun | | ITEM#23a perPHYG781 3/ 1. Decedent's Neme (First, Middle, Last, | | | of Death | 2. Date of Deatl | | | ime of Death |
|---|--|---|---|--|--|---|---|---|---|
| | ician | David | Wilson | Weaver | Sr. | Month January | Dey | Yeer 000 | 0923 |
| /ivied | dicai niner | 4e. Fecility Neme (If not institution, give | | | 4b. City, Town, or I | | 4c. County | | 0223 |
| | | The Kent and Queen | Anne's Hosp | ital, Inc. | Chester | town | Ke | nt | |
| Funera Directo | | 5. Sociel Security Number 6. Sec. 220-32-9547 | 7. Age (In yrs. | Months De | eer If Under 24 Hrs. eys Hours Min. | 8. Date of Birth (Month, Day, Feb. 10 | | | State or Foreign |
| pue Mend | | 10a. State 10b. County | 10c. Cit | y, Town or Location | | | | 10d. Ins | side City Limits |
| Men | ţō | Md. Queen A | nne's He | enderson | | | | 10 | Yes 2 No |
| or 28 | i e | 10e. Street and Number | | 10f. Zip Co | | 10 | g. Citizen of V | Vhat Country? | |
| 23a | ral | 1054 Bridgetown | Road | | 21640 | | USA | 1 | |
| Z 1 Z 1 S-UUZU d within 72 hours after death with the Meryland glene. In then "naturel", or freme 23s or 28s-f show in Medical Examiner must be notified at | by Funeral Director | 11. Marital Stetus 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. Wes Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give XX Year or Dates: | ,S. 13. Was Decedent if Yes, specify | of Hispanic Origin? (S Cuben, Mexican, Puert No Specify: | pecify Yes or No- o Rican, etc.) | | e - American Ind ik, White, etc. Whit | |
| 72 ho | ted | 15. Decedent's Edu (Specify only highest grade | cation | 16a. Decedent's Usual O | ocupetion | tring | 16b. Kind of Bu | isiness/Industry | |
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| be filed withintal Hygiana. | | 12 17. Fether's Name (First, Middle, Last) | | Carpenter | 19 Mothor's Nam | ne (First, Middle, N | Inidan Cumam | 0.1 | |
| Maryland a 2 should be filed the and Mental Hygist is marked other traumatic event, it | Be | Wilson B. Weave | r | | | t H. Hui | | θ) | |
| gas 1 and 2 should b to of Haalth and Ments if item 27 is marked or other trsumatic e | L _O | 19a. Informant's Name/Relationship (Ty | | 19b. Mailing Address (St | | | | State, Zip Code |) |
| Haalth ar Haalth ar em 27 is other trau | | Vivian Weaver (| Wife) | 1054 Bridg | etown Rd | ., Hende: | rson, | Md. 21 | 640 |
| baltimore, semit. Pegas 1 ar Department of Haa mportant: if item; | | 20a. Method of Disposition 1 | | Placa of Disposition (Name of Semetery, crematory or other | nlace) | | 20c. Location - | City or Town, St | ate |
| Peg mant ant: It | 40 | 4 Donation 5 Other (Specify) | | esterfield | Jan. Cemetery | 7,2000 | Centre | ville, | Md. |
| permit. Pegas 1 and 2 Department of Health Important: If them 27 is | - Suce | 21. Signature of Funeral Service License | 96 | 22. Name end A | ddress of Facility , Helfenbe | oin 9 Nu | or in a m | Funora | 1 Hom |
| 40500 | a | 23a. Part1. Enter the disease, or complishook, or heart failure. List only dr | efreum. | 408 S. | Liberty : | St. Cer | ntrevi | | |
| Physician /Medica Examine | al er | Immediate Cause (Final disease or condition resulting in death) | - 5 UD | or as a consequence of): | EATI | } | | | |
| cata be axecuted physician and s tha burial-transit | Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | Due to (a | or as a consequence of): | | | | | |
| E 01 40 | edical | Cause (Disease or Injury that initiated events resulting in death) Last | Due to (o | r as a consequenca of): | | | | | |
| S & ipus | Physician/M | | l | | | | | 1 | |
| 3 # # 5 | 18 | Part II. Other significant conditions con | tributing to death but not res | ulting in the underlying cause | e given in Part I. | 23b. Did to | bacco use cor | ntribute to the c | ausa of death? |
| the atta | - | | | | | | | OF Brokens | |
| d by the deteched | by | DIEENSE | HISTIC | ochtec T. | motton | | 2 2 No | | |
| e law requires that the death cer has been signed by the attandin ja 2 should be deteched for use | by | DIEENSE | HISTIC | octic 2 | AmpHom | 24a. Was ar | n autopsy | 24b. Were aut | opsy findings prior to on of cause |
| ii: The law requires that the death icata has been signed by the attar, r, paga 2 should be deteched for | Completed by | | HISTIC | octic 2 | Tupton | 24a. Was ar | n autopsy ned? | 24b. Were aut evallable completion | opsy findings prior to on of cause |
| sician: The law requires that the death cartificate has been signed by the atta lirector, page 2 should be deteched for | Be Completed by | 25. Was case referred to medical examiner? | HISTI C | CYTEC 2 | 26. Piece of Dea | 24a. Was ar perform | n autopsy ned? | 24b. Were autevallable completion of death? | opsy findings prior to on of cause |
| ysician: The law requires is carrilicate has been sign director, page 2 should be | To Be Completed by | 25. Was case referred to medical examiner? | 28a. Date of Injury | ER/Outpetient 3 DOA 28b. Time of 28c. | 26. Plece of Dea | 24a. Was ar perform | n autopsy ned? s 2/100 | 24b. Were autevallable completion of death? 1 Yes | opsy findings prior to on of cause |
| ysician: The law requires: siscarificate has been signidirector, page 2 should be | To Be Completed by | 25. Was case referred to medical examiner? 1 □ Yes 2 ☑ No | 1 □ Inpatient 2,227 | 28b. Time of 28c. | 26. Piece of Dea | 24a. Was ar perform 1 Ye th (Check only one one 5 Reside | n autopsy ned? s 2/100 | 24b. Were autevallable completion of death? 1 Yes | opsy findings prior to on of cause |
| TWASTOLING Physician: The law requires for death. Treator: Affar this cartificate has been sign in by the funaral director, page 2 should be | o Be Completed by | 25. Was case referred to medical examiner? 1 Yes 250 No | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury M | 26. Plece of Dea Other: 4 Nursing H Injury at Work? 1 Yes 2 No | 24a. Was ar perform 1 Ye th (Check only one one 5 Reside | n autopsy ned? s 25 No s) nca 6 5 this w Injury occurr | 24b. Were autovallable completic of death? 1 Yes ar (Specify) | opsy findings prior to an of cause |
| Attending Physician: The law requires that death. Irector: Affar this certificate has been sign in by the funaral director, page 2 should be | To Be Completed by | 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Neturat 5 Pending Investigation 3 Sulcide 6 Could not be determined 29a. Certifier 1 Cartifying Phys | 28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At ho | 28b. Time of Injury M 28c. M 2 | 26. Plece of Dea Other: 4 Nursing H Injury at Work? 1 Yes 2 No | 24a. Was ar perform 1 Ye th (Check only one ome 5 Reside 28d. Describe ho City or Town) | n autopsy ned? s 2/1 No e) nca 6 □Othe w injury occurr reet and Number, State) use(s) and ma | 24b. Were autevallable completic of death? 1 Yes ar (Specify) red are or Rural Route | opsy findings prior to on of cause |
| tending Physician: The law requires death. tor: Affar this cartificate has been sign if the funeral director, page 2 should be | Certification: To Be Completed by | 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Neturat 5 Pending Investigation 3 Sulcide 6 Could not be determined 29a. Certifier (Check only 2 Medical Examin | 28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At he building, etc. (Specification). | 28b. Time of Injury M ome, farm, street, factory, of Wedge, death occurred at the tion and/or Investigation, in recognitions. | 26. Plece of Dea Other: 4 Nursing H Injury at Work? 1 Yes 2 No | 24a. Was ar perform 1 Ye th (Check only one ome 5 Reside 28d. Describe ho 28f. Location (Str. City or Town , and due to the carred at the time, da | n autopsy hed? s Allo a) nca 6 Other w Injury occurr reet and Numb. State) use(s) and ma | 24b. Were autevallable completic of death? 1 Yes ar (Specify) red are or Rural Route | opsy findings prior to on of cause No No No Number, |
| Attending Physician: The law requires far death. Irector: Aftar this certificate has been sign in by the funaral director, page 2 should be | edical Certification: To Be Completed by | 25. Was case referred to medical examiner? 1 | 28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At he building, etc. (Specification) clotten: To the best of my known or on the basis of examinar and manner stated. | 28b. Time of Injury M ome, farm, street, factory, of wledge, death occurred at the tion and/or Investigation, in r 29c. Lie | 26. Plece of Dec Other: 4 Nursing H Injury at Work? 1 Yes 2 No iice be time, date and place my opinion, death occu | 24a. Was ar perform 1 Ye th (Check only one ome 5 Reside 28d. Describe ho 28f. Location (Shr City or Town and due to the carred at the time, da | n autopsy ned? s No a) nca 6 Othe w Injury occurr reet and Numb , State) use(s) and ma | 24b. Were autovallable completic of death? 1 Yes ar (Specify) red er or Rural Route nner as stated, and due to the completic of death? | prior to on of cause No No No Number, suse(s) |



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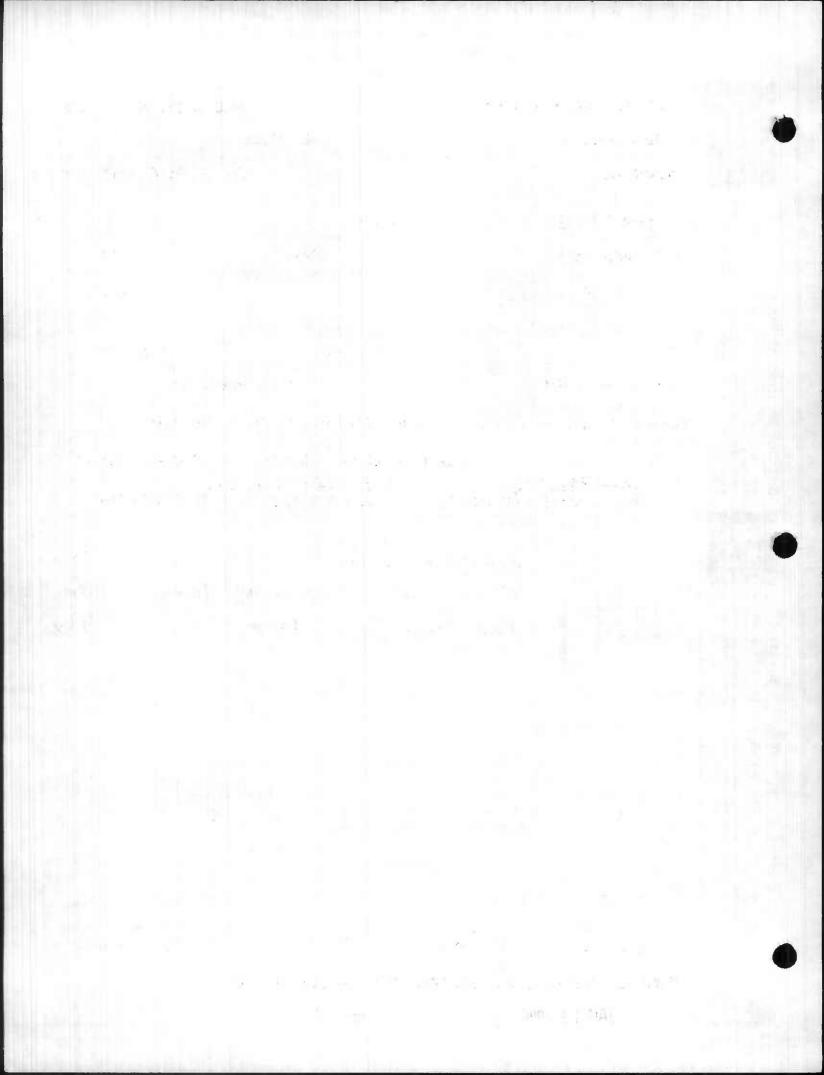
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death **Physician** William Grier Whitley JANUARY 12, 2000 9:35 AM · /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 9190 Sadie Lane La Plata Charles 5. Social Sacurity Number 6. Sax 1 → M 2 □ F If Undar 1 Yaar If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) Feb. 9, 19 7. Aga (In vrs. last birthday) Birthplaca (Stata or Foraign Country) **Funeral** Months Days Hours Min. 75 Yrs. 1924 242-20-9030 North Carolina Director Usual Rasidance of Dacedani the Maryland 10a Stata 10b. Count 10c. City, Town or Location 10d. Insida City Limits Item 27 is marked other than "natural", or itema 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 1 ☐ Yas 2 X No Director La Plata Maryland Charles 10e Street and Number 10f. Zip Coda 10g. Citizan of What Country? with 9190 Sadie Lane 20646 USA Funeral death 12. Was Dacedant Evar in U,S. Armed Forcas? 13. Was Decedant of Hispanic Origin? (Spacify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amaricen Indian, Black, Whita, atc. 2 should be filed within 72 hours after and Mantal Hygiena. 1 XYas 2 No If Yas, Giva Yaar or Datas: 1 Navar Married 2 X Married Saltimore, Maryland 21215-0020 1 Yas 2 XNo Specify: Specify: White þ 3 Widowad 4 Divorced Completed 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Spacify only highast grada complated) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) Collega (1-4or 5+) Truck Driver Giant Food 10 18. Mothar's Nama (First, Middla, Maidan Sumama) 17. Fathar's Nama (First, Middla, Last) William Grier Whitley Essie Mae Love 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) permit. Pages 1 and 2 sh Department of Haelth and Important: If Item 27 Is m any injury or other treun page. 9190 Sadie Lane, La Plata, MD 20646 Margaret H. Whitley - Wife 20b. Place of Disposition (Nama of cematery, crematory or other place) 20c. Location - City or Town, State 20a. Mathod of Disposition 1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Maryland Veterans' Cemetery 1-19-2000-Cheltenham, MD 21. Signature of Funeral Service Licensee 22. Name and Addrass of Eacility
Huntt Funeral Home, Inc. un John P. Knisley P. O. Box 156, Waldorf, MD 20604-0156 M01164 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heert fellure. List only one cause on each line. Approximete Injarval Between Onset and Death **Physician** /Medical immediata Causa (Final diseasa or condition Examiner Examiner Candipuasurins physician and the burial-transit Sequantially list conditions, if any, laeding to immadiata causa. Entar Undarfying Causa (Disaasa or Injury that initiated avants rasulting in daath) Last certificate be exec Records, P.O. Box 68760 Dua to (or as a consequence of) Physician/Medical as use i for ed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by t d be detach 1 Yee 2 No 3 Probably 4 Unknown p 24b. Wara autopsy findings available prior to complation of causa of death? 24a. Wes an autopsy parformed? Completed peeu has certificata 1 Yas 1 ☐ Yas 2 ☐ No Division of Vital funeral director, 25. Was casa rafarrad to medical axaminar? Be 26. Placa of Death (Check only ona) Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Spacify) 1º 1 ☐ Yes 2 No 1 Inpatiant 2 ER/Outpatient 3 DOA this 28a. Data of Injury (Month, Day Year) 28d. Dascribe how Injury occurred 27. Mennar of Death Certification: 28b. Time of 28c. Injury at Work? After 1 Natural 2 Accidant 5 Panding Invastigation i or Attending after death. Director: After 1 Yas 2 No Could not be datarmined 3 ☐ Suicida Location (Streat and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 4 Homicida A 24 hou. 1 Cartifying Phyelcian: To the bast of my knowledge, death occurred et the tima, deta and placa, and dua to the cause(s) and mannar as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, dete end place, and due to the cause(s) and manner stated. 29a. Cartifiar Medical completaly (Check only one) To the I 29d. Data signad (Month, Day, Year) 29b. Signatura and titla of certifiar 29c. Licansa number Thomas Litalola ON 001923 JAN 13, 2000 30. Nama and addrass of person who completed cause of deeth (Item 23a) (Type, Print) THOMAS L. FIELDSON, MD, 2068 CRAIN HWY., WALDORF, MD 20601

State Registrar 31. Data filad (Month, Day, Year)

JAN 1 8 2000

32. Registrer's Signetura

B. Sparks



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** EMMETT M. WILLIS 11, 2000 10:45 A.M. January /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 2009 Woodreeve Road Avondale Prince George's 8. Date of Birth (Month, Day, Year) June 14, 1919 If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Virginia If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 10M 2□ F 80 227-44-5180 Yrs Director Usual Residence of Decedent the Maryland J Hygiene. other than "natural", or frama 23a or 28a-1 show vant, the Medical Examinar must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐Xes 2 ☐ No Director Powhatan Virginia Powhatan 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2307 Anderson Highway 23139 United States Funeral 12. Was Decedent Ever in U,S.
Arrued Forces?
1 ☐ Yes 2 ☐ No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Rece - American Indian, Black, White, etc. 11. Merital Status filed within 72 hours after 1 Never Married 2 Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: Black à 3 Widowed 4 □ Divorced Yeer or Detes: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Private Auto Mechanic 17. Father's Name (First, Middle, Last) 18. Mother'a Name (First, Middle, Maiden Surname) . Pages 1 and 2 ahould be fit transfer of Health and Mental Hant: If Itam 27 is marked off jury or other traumatic aver Be David Dunn Willis Carrie Jasper 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Vivian Littlefield - Daughter 2009 Woodreeve Rd., Avondale, MD 20782 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Cem. 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Calvary Bapt. Ch. 1/15/2000 Chesterfield Co., VA Mt. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stewart Funeral Home lewart 4001 Benning Rd., N.E. Wash., D.C. 20019 Mon Finter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** /Medical Immediate Cause (Final cancer of disease or condition resulting in death) Examiner Examiner physician and s the burial-transit that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequence of): Box 68760. Physician/Medical Due to (or as a consequence of): PO Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 2 1 Tes 2 No 3 Probably 4 Nunknown signed bed bed Division of Vital Records. by The law requires 24b. Were autopsy findings available prior to 24a. Was an autopsy Completed completion of cause of death? page 2 1 ☐ Yes 2 ☑ No 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, t Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Daughter's 1 Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Naturat 5 Pending 1 Yes 2 No investigation 2 Accident 3 Suicide 6 Could not be determined 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) rubion D23743 January 12, 2000 30. Name and address of person who completed cause of death (Item 33a) (Type, Print) Martin D. Weltz, 7525 Greenway Center Drive, Greenbelt, MD 20770 31. Date filed (Month, Day, Year)

JAN 1 3 2000 32. Registrar's Signature State

DHMH 16 Rev 6/95

Registrar

Secretary Description

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygie

| | 0 | 0 | 0 | 0 | 1 | 0 | |
|----|---|---|---|---|---|----|--|
| ne | U | U | U | 2 | H | 6. | |

00-0162-033

Certificate of Death

Physician /Medical Examiner

Vaughn DeCarlos Williams 4a Facility Nama (If not institution, give street end number)

1. Decedent's Name (First, Middle, Last)

Month **JANUARY** 10 2000 4b, City, Town, or Location of Death

2. Date of Death

4591 ALLENTOWN RD. **CAMPSPRINGS**

4c. County of Death PRINCE GEORGES

Funeral Director

must be n

6

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be nent of Health and Mental

nt: if item 27 is Y or cell

Physician

/Medical Examiner

Examiner

Physician/Medical

þ

Completed

Be

detached

6 bengis Funeral

à

Completed

10a. Stata 10b. County

5. Social Security Number

577-90-2804

10c. City, Town or Location

Yrs.

7. Age (In yrs. last birthdey)

27

8. Date of Birth (Month, Dey, Year) June 13, 1 1972

 Birthplace (State or Foreign Country) WASH.,

10d. Inside City Limits

3. Tima of Death

0159

Usual Residence of Decedent notified at

Directo Maryland

Prince George's

1 MM 2 □ F

Temple HIlls

XXYes 2 No 10g. Citizan of What Country?

10e. Street and Number

3880 26th Ave 20748

If Under 1 Yaar | If Under 24 Hrs.

Hours

Days

10f. Zip Coda

USA

11. Marital Status

1 Never Married 2 Married 3 Widowed 4 Divorced

12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas ②XXNo If Yes, Give Yaar or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 1 Yes 2 No Specify:

14. Raca - American Indian, Black, White, etc. BLACK

16h Kind of Business/Industry

15. Decedent's Education (Specify only highest grade completed)

Elemantary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) PACKER

PRIVATE INDUSTRY

17. Fathar's Name (First, Middle, Last)

ALPHONSO WILLIAMS, SR.

18. Mother's Name (First, Middle, Meiden Sumema)

CAROL BUTTONE

19a. Informant's Name/Ralationship (Type, Print)

Alphonso Williams, Sr./ father

19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3392 Curtis Dr. #202 Temple Hills, Md

20c. Location - City or Town, State

20a. Method of Disposition

1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Neme of cemetery, cremetery or other place) Harmony Memorial Park

1-14-00

Landover, MD

21. Signature/of Funeral Service Licensee

22. Name and Address of Facility Marshall's Funeral Home of MD 4308 Suitland Rd. Suitland, MD 20746

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disaasa or condition rasulting In death)

| Multi | ple o | unshot | wounds |
|-------|-------|--------|--------|
| | | | |

Dua to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of)

Dua to (or as a consequence of)

Part II. Other eignificant conditions contributing to death but not resulting in the undarlying cause givan in Part I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

24b. Were autopsy findings available prior to completion of cause of death?

Approximata Intervat Betwe Onset and Death

1 X Yes 2 □ No

26. Place of Death (Check only ona)

1 N Yes 2 No

25. Was case referred to medical XXYes 2□ No

27. Manner of Death 5 Pending 1 Natural 2 Accident

Invastigation -10-00 6 Could not be datamined

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 28b. Time of 28c. tnjury at Work? Injury 0155

1 Yas 2 No

28d. Dascribe how injury occurred

111 Penn Street, Baltimore, Maryland 21201

Subject was Shot 281. Location (Street and Number or Rurel Route Number, City or Town, State) 4591 Allentown Read Prince Georges County, Maryland

29a. Certifier (Check only one)

3 Sulcida

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated. 29b. Signatura and title of certifian

Parking

29c. License number O.C.M.E

29d. Date signed (Month, Day, Year) **JANUARY** 10,2000

MP 30. Name and address of person who completed cause of daath (tam 23a) (Type, Print)

Stephen S.
31. Date filed (Month, Day, Year) Radentz M.D

JAN 1 3 2000

32. Registrar's Signature

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

lot

DHMH 16 Rev 6/95

Box 68760. P.O. Records. of Vital Division

The law requires that the death certificate be assecuted page or Attending Physician: After after death. Director: Af To the Hospital within 24 hours a To the Funeral I completely filled Hospital

Medical Certification: To

State Registrar

James & final

CCC FINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

| | | | | | Ce | rtifica | te of | Death | | Reg. No. | J | 124 | 2.5 |
|---|---------------------|---|----------------------------|---|------------------|-------------------|------------------------|--|-------------------------------------|----------------------|---|-----------------------------|--------------------------|
| | | 1. Decedent's Nema (First, Midd | lle, Last) | | 100 | | | | 2. Data of De | ath | Vala | 3. Tima | of Death |
| Physicia /Medica | | Nancy | | L. | | Weav | er | | Jan | Day | Yaar | 2.3 | 5 PM |
| Examine | | 4e. Facility Nama (If not institution | on, give street and | | | | | 4b. City, Town, or | | B | W to the | | |
| | | Washington A | dventis | st Hosp | ital | | | Takoma | Park | Mo | nton | mery | |
| Funeral | | 5. Social Security Number | 6. Sex | 7. Aga (In yrs | . last birthday) | If Unda Months | ar 1 Year Days | Takoma If Undar 24 Hrs Hours Min. | | th | 9. Birth | place (Stat | e or Foreign |
| Director - | | 218-88-5844 | 1□ M 2 /C XF | 27 | Yrs. | | Duyo | 110010 | Jan. 3 | 1973 | | aryla | |
| ms 23a or 28a-f show | | Usuel Residence of Dacadant 10e. Stata 10b. Count | , | 100.0 | ity. Town or Lo | nantina | | | | | | | |
| r 28a-f show a notified at | 7 | | | | | | | | | | | | City Limits as 2 □ No |
| Page 1 | octo | | e George | s S | eabrool | | | | | _ | | | as ZLINO |
| Pen l | 吉 | 10e. Street and Number | | | | 10f. Zi | p Coda | | | 10g. Citizan of | What Cou | ntry? | |
| 23a | ra l | 9402 Wellingto | | | | | 207 | | | U.S.A | | | |
| - M | by Funeral Director | 11. Marital Status 1 XNevar Marriad 2 Ma 3 Widowed 4 Divorca | ried 1 \(\text{Yas} \) | ecedant Evar in U Forcas? s XIX No Give r Datas: | | | | Hispanic Origin? (Sean, Maxican, Puarl Specify: | pecify Yas or No to Rican, atc.) | | ce - Amari ick, White, ^{fy:} Whi | | |
| natural polical Ex | Be Completed | 15. Deceda | nt's Education | | 16a. Dece | dant's Usi | ual Occu | pation | | 16b. Kind of B | | | |
| C S | pie | (Specify only higher Elamantary/Secondary (0-12) | | a (1-4or 5+) | (Give | DO NOT | ork done use retire | during most of word) | rking | | | | |
| giene. | Š | 0 | 0 | . (1 401 01) | | None | | | | Non | ie | | |
| Department of Health and Mental Hygis Important: if Nem 27 is marked other any Injury or other traumatic event, Il once. | Se C | 17. Fathar's Nama (First, Middle | Last) | | | -110116 | | 18. Mothar's Nar | ma (First, Middle | , Maiden Sumar | n <i>e)</i> | | |
| rked tic e | 0 | Charles H. W | eaver | | | | | Eleano | r Carte | er | | | |
| and Mental is marked of aumatic eve | | 19a. Informant's Name/Ralation | ship (Type, Print) | | 19b. Mailie | ng Addras | s (Stree | and Number or Ru | | | , State, Zi | p Code) | |
| 27 is | | Charles H. Wea | ver (Fath | ner) | 9402 | 2 Wel | ling | ton Stre | et Seabi | ook, MD | 2070 | 06 | |
| If Nem 27 is marked other or other traumatic event, | | 20a. Mathod of Disposition | | | Placa of Dispo | sition (Na | me of | | Date | 20c. Location | | | |
| 7. If | | 1 Donation 5 ☐Othar | 3 ∐Ramovai fro Specify) | m State | | | | Cemeter | 1/1// | 00 Adolo | hi i | MD | |
| mportant: mportant: any injury | | 21. Signature of Emeral Service | | 7 | | 2. Name e | nd Addra | ass of Facility | | _ | 111 | עני | |
| any le | | > Side | 119 | | | | | ale Fune | | | | | |
| | - | 23a Part V Enter the disease of | complications the | ot caused the dee | th. Do not ont | 9013 | Ann | apolis Ro | d. Lanha | m, MD 2 | 0706 | Approxim | |
| 7.00 | | 23a. Pert Enter the disease, of the ck, or heart failura. Lis | only one cause of | n aach lina. | III. DO HOL GIII | iei (iie iiio | s | ng, such as cardia | c or raspiratory a | iirest, | 1 | Intarval E Onset an | Betwaen |
| ysician Medical | | mmadiata Cause (Final | | 0 | | 1 13 | | | | | | | - |
| aminer | | disease or condition rasulting in death) | a | fnells | mar | 4 | | | | | | 3. mis | works |
| | - | | | Due to (| or as a consec | quence of) |): | | | | 1 | | , |
| nsit. | Examiner | | b | | | | | | | | 1 | | |
| al-tra | Xar | Sequantially list conditions, if any, leading to immadiate causa. Entar Undarlying Cause (Diseasa or Injury | | Due to (| or as a consec | quance of) |): | | | | i | | |
| burie | | causa. Entar Undarlying Cause (Diseasa or Injury | c | | | | | | | | i | | |
| ng physician end s as the burial-transit | Medicai | that initiated events resulting in daath) Last | | Dua to (| or as a conseq | uanca of) | : | | | | | | |
| ding Se as | | | d | | | | | | | | | | |
| for use | lan | | | | | | | | | | | | |
| thed | Physician/ | Part II. Other eignificant conditi | | | | | cause gi | ven in Part I. | 23b. Dld | tobacco uee co | ntribute t | o the caue | e of death? |
| ed by the ettendin | Ph | | | 50/191 | Cenn | 9 | | | 1 🗆 | Yes 22 No | 3 Pro | bably 4 | Unknow |
| 6 8 | by | | | | | | | | | | T | | |
| should | Completed | | | | | | | | 24a. Was | an autopsy ormed? | 10 | era autops vailable pric | or to |
| as b | pie | | | | | | | | | | | ompletion of death? | T cause |
| page | 0 | | | | | | | | 1 🗆 | Yas 2 No | 11 | ☐ Yas 2 | □ No |
| | Be | 25. Was casa rafarrad to medica examiner? | il | | | | | 28. Place of Dea | ath (Check only | one) | | | |
| 0 0 | 2 | 1 ☐ Yas 2 € No | Hospital: | Inpatient 2 | ER/Outpatier | nt 3 D | OA OI | har: 4 Nursing H | loma 5 ☐ Ras | danca 6 Oth | nar (Speci | ify) | |
| ter th | | 27. Manner of Daath | | te of Injury onth, Day Year) | 28b. Tima o | f | 28c. Inju Wo | ry at | 28d. Describe | how injury occur | rred | | |
| eth. r: After se funer | atic | 1 ØNatural 5 ☐ Pandi 2 ☐ Accidant invest | gation | orar, ouy rour, | Injury | М | | Yas 2 □ No | | | | | |
| ofter deeth. Director: A J in by the fu | 110 | 3 ☐ Suicida 6 ☐ Could 4 ☐ HomicIda detarr | nined 288. Pla | ica of Injury - At h | oma, farm, str | aat, facto | ry, office | | 28f. Location (City or To | Street and Numi | ber or Rur | al Route N | umber, |
| o d in | Certification: | V _ 1.0molou | bui | ioling, atc. (Speci | '97) | | | | City or 10 | wii, State) | | | |
| within 24 hours efter deeth. To the Funeral Director: After thi completely filled in by the funeral | le | 29a. Cartifier 1 Certifyi | ng Phyalcian: To t | ha bast of my kno | owledga, daatt | h occurred | at tha ti | me, data and place | ı, and dua to the | causa(s) and m | annar as s | stated. | |
| Ne Fu | edical | (Check only 2 Medical one) | Examiner: On the | basis of axamina annar stated. | ation and/or in | vestigation | n, In my | opinion, daath occu | irred at the time, | date and placa, | and dua t | o tha cause | e(s) |
| To the | Ž. | 29b. Signatura end titla of cartific | I (M) | A M | D | 29 | c. Lican | se number | | 29d. Dete signe | ed (Month, | Dey, Year |) |
| | | | 1 por | X | , | | 24: | 183 | | 1/01. | 2000 | | |
| 4) | | 90. Name and address of account | 32 | U | m 00th /T = | Deleth | , , , | 183 Ve Lou | 77 | 1./0 | 100 | | |
| | | 30. Name and address of person | what complated ca | Z/ La | A in | Print) | A | Va Lou | nol 1 | 10 20 | 707 | * | |
| 0: | | 31. Date filed (Morth, Day, Year | 7 190. | Ranietrario Sian | atura | | | • | | | | | |
| State | | JAN 1 3 20 | 00 % | Ragistrar's Sign | atura 4 | Lan | | , | | | | | |

DHMH 16 Rev 6/95

The state of the s

State Registrar

31. Date filed (Month, Day, Year)

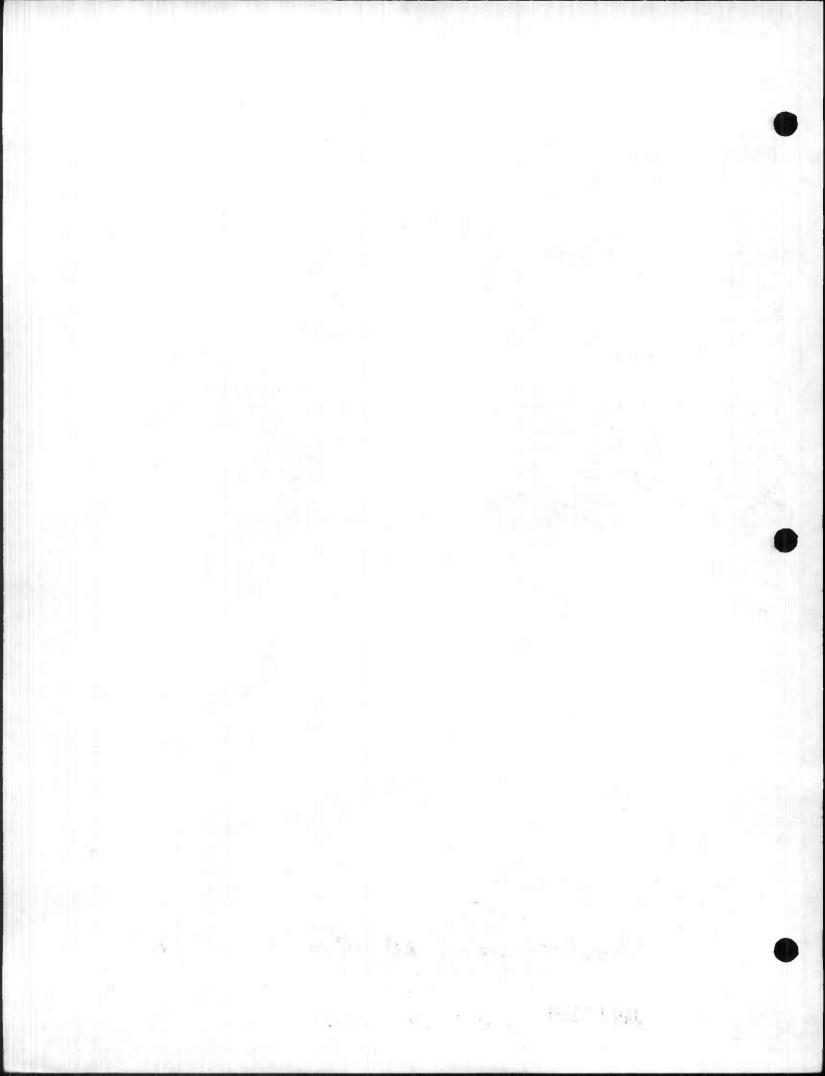
JAN 1 1 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Myron Lenkin 2309 Shorefield Rd., Silver Spring, Md. 32. Registrar's Signature

DHMH 16 Ray 6/95

20902

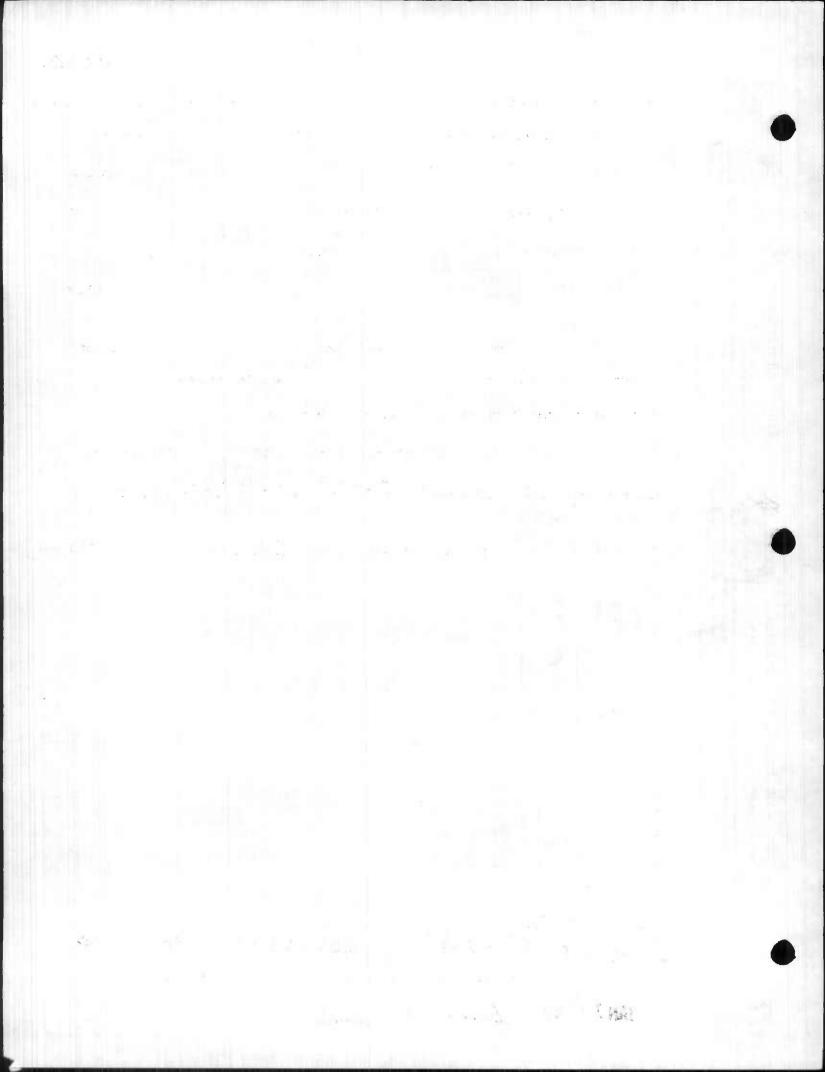


Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 021, 27

| | | | Ce | ertificat | e of | Death | F | leg. No. | UU | 1646 | 1 |
|---|---|--|---|-------------------------------|----------------|--|---|-----------------------------|-------------------------------------|--|-------------|
| Physician | 1. Decedent's Nama (First, Middla, Last Margaret O. Wash | | | | | | 2. Data of Dea Month | Dav | Year | 3. Time of De | |
| /Medical | 4a Facility Name (If not institution, give | | | | | 4b. City, Town, or I | January | - | 000 ty of Death | 9:30 | AM |
| Examiner | Montgomery Gene | | The state of | | | Olney | | | gomer | | |
| Funeral Director | 377 42 1020 | 7. Aga (In) | rs. last birthda 66 Yrs. | Months | 1 Year Days | If Undar 24 Hrs. Hours Min. | 8. Data of Birtl (Month, Day 5/4/33 | | | placa (Stata or Fintry) h., D.C. | Foraign |
| and w | Usuai Rasidence of Decedant 10a. Stata 10b. County | 10c. | City, Town or I | Location | , | | | | | 10d. Insida City | Limits |
| Mary Mary Mad ah | Md. Montgo | mery | Silve | r Spri | ng | | | | | MXYes 2 | 2 □ No |
| th with the Ma 23a or 28a-f a at be notified | 10e. Street and Number 15020 Butterc | hurn Lane | | 10f. Zip | | 905 | | | 0g. Citizan of What Country? U.S.A. | | |
| Definition of the state of the | 11. Marital Status 1 Nevar Marriad XX Married 3 Widowed 4 Divorced | 12. Was Decedent Ever in Armed Forcas? 1 ☐ Yas 2 ☐ No lif Yes, Giva Yaar or Datas: | Forcas? If Yas, specify Cuban, N s 2 No Giva 1 Yes 2 No S | | | pecity Yas or No- o Rican, atc.) | | | | | |
| 72 ho | 15. Decedant's Edu (Specify only highast grad | ucetion la complated) | (Giv | adant's Usua 'a kind of wo | rk dona | during most of wor | king | 16b. Kind of | Businass/In | idustry | |
| led within 72 hou lygiene. her than "naturati, the Wed call. | Elementery/Secondery (0-12) | Collaga (1-4or 5+) | 1.31 | chool | | | | E | ducat | ion | |
| be filed tal Hygin d other event, the | 17. Father's Nama (First, Middla, Last) | _ | | | | 18. Mothar's Nar | ne (First, Middla, | | | | |
| Menta | John Henry O | liphant | | | | Sall | ie Drumm | ing | | | |
| and 2 should be file and 2 should be file ath and Mental Hy 27 is marked oth or traumatic event TO Be (| 19a. Informant's Name/Ralationship (7) Reginald Washingt | | | | | tand Number or Au Dabove | ral Route Numbe | r, City or Tow | n, Stata, Zip | p Code) | |
| Memit. Peges 1 ar Pepartment of Hea Montant: If Item iny Injury or other ance. | 20a. Mathod of Disposition 1 Burial 2 Cramation 3 F 4 Donation 5 Other (Specify) | Ramoval from Stata | b. Place of Dis cematary, cr Lincols | am atory or o | othar pla | | Data /00 | 20c. Location Suitla | | | |
| mporti mporti any in | 21. Signatura of Funaral Sarvice Licens | W. Gra | ut | 22. Nama an H.S.W 4925 | ash: Bur | ess of Facility ington & roughs Av | Sons Co. e.,N.E., | ,Inc. Wash., | D.C. | 20019 | |
| | 23a. Pert1. Enter the disease, or complishock, or heart feilure. List only of | licetions that caused the d ne ceuse on each line. | eath. Do not e | ntar tha mod | a of dy | ing, such as cardia | or respiretory ar | rest, | | Approximete Interval Batwe Onset and De | een eeth |
| Physician /Medical Examiner | Immediate Cause (Finel disaasa or condition resulting in daath) | | e M | | urdi | al Info | arction | | | 90 mi | |
| si ed | | b | | | | | | | i | | |
| rificate be axecuted and physician and as the buriel-transit | Sequantially list conditions, if any, laading to immediata causa. Entar Undarlying Causa (Disaasa or injury | Due t | o (or es a cons | equance of): | | | | | | | |
| E 0 2 | that initiated evants rasulting in daath) Last | Due to | o (or as a cons | aquance of): | | | | | | | |
| death ca death ca d for use | Part II. Other significant conditions con | ntributing to death but not | rasulting in the | undarlying c | AUSA O | ivan in Part I. | 23b. Dld t | obacco use o | ontribute | to the ceuee of | death |
| v requires that the death ca been signed by the ettendi should be deteched for use leted by Physician/I | Diabetes | | | | 1 ☐ Yes 2 ☐ No | | | | | | - |
| or Attending Physician: The law requires the star death. Director: After this certificate has been signed in by the funeral director, page 2 should be certification: To Be Completed by | | | | | | | 24a. Was perfor | an autopsy med? | av Cd | Vara autopsy fine vallabla prior to completion of ceu of daath? | |
| The law ate has pege 2 | | | | | | | 101 | as 2 No | 1 | ☐Yes 2☐N | 10 |
| elan: entifica ector, Be | 25. Wes cese referred to medical | (1 | | | | | eth (Check only o | ne) | | | |
| ling Physician: After this certific funeral director, | 1 Nas 2 No 27. Manner of Death 1 Natural 5 Panding | 1 Inpatient 28a. Date of Injury (Month, Day Yea | 2 DER/Outpeti 28b. Tima Injury | of 2 | 28c. Inju | | loma 5 Rasid 28d. Describe h | | | ify) | |
| To the Hospital or Attending Physician: The is within 24 hours after death. To the Funeral Director: After this certificate ha completaly filled in by the funeral director, page: Medical Certification: To Be Com | 2 Accidant invastigation 3 Suicide 6 Could not be 4 Homicida datamined | 28a. Place of Injury - Abuilding, atc. (Sp | At home, farm, acify) | | | | 28f. Location (S City or Tox | Straat and Nur m, Stata) | n <i>ber or R</i> ur | ral Routa Numbe | Θľ, |
| To the Hospital of within 24 hours at To the Funeral D completaly filled in Medical Ce | | elclan: To the best of my iner; On the basis of exam and mannar stated. | | | | | | | | | |
| Within To the comple | 29b. Signatura and titla of pertifiar | 72- | | | | se number | | 29d. Date sign | | | |
| | Den soll | One | P. | [| 00 | 02587 | 7 : | TAN-8 | -201 | 00 | |
| | 30. Nama and addrass of person the co | | item 23a) (Typ | e, Print) hilip L | 00, | olney n | 10 208 | 32 | | | |
| State Begistrar | 31. Dete filed (Month, Day, Year) | 32. Registrer's S | ignature | 1 | 3 1132 | | | | | | |

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

|) | | /Med Exam | tica |
|------------|--|---|------------------------------|
| | | unera irecto | |
| 21215-0020 | ed within 72 hours after death with the Maryland | yperson er then "natural", or herve 23a or 28a-f show 4, the Medical Examiner must be notified at | Completed by Eurage Director |

Division of Vitai Records, P.O. Box 68760,

| 1. Decedent's Neme (First, Midd | | | | | | | | | | | |
|--|--|---|--|---|---|--|--|---|---|--|--|
| | Bill - St | E | 1.7 4.1 | | | | | 2. Dete of D | Dey | Yeer | 3. Tima of Dea |
| | | eorge E. | warth | ien | | | | Januar | 2 | | 8:00PM |
| le Fecility Name (If not institution | | d nu <i>mber)</i> | | | _ 4 | 6b. City, To | wn, or Lo | ocation of Dea | th 4c. County | of Death | |
| 6336 Rosecroft | _ | | | | | Fort | Wash | ington | Princ | | orge's |
| 5. Social Security Number | 6. Sex 1 → M 2 □ | E . | rs. last birtho | Months | or 1 Yeer Deys | Hours Hours | Min. | 8. Dete of Bi (Month, D | ey, Year) | 9. Birth | plece (State or For |
| 214-18-9139 | X Z | 84 | Yn | S. | | | | Nov. 2 | 4, 1915 | Wilm | ington.D |
| Usuel Residence of Decedent 10a. Stete 10b. Count | <u> </u> | 100 | City, Town o | v Location | | | | | | | 10d. Inside City Li |
| Maryland Howa | | | lkridg | | | | | | | | 1 ☐ Yes 2X |
| | | | TKI TUE | | | | | | | | |
| 10e. Street and Number | | | | 10f. Z | ip Code | | | | 10g. Citizen of \ | What Cou | intry? |
| 5667 Landing | Road | | | | 2122 | 7 | | | USA | | |
| 11. Merital Stetus | | Decedent Ever in d Forces? | U,S. | 13. Wes Dec | edent of H | ispanic On | gin? (Sp | ecify Yes or N Rican, etc.) | 0- 14. Red | e - Ameri | can Indian, |
| 1 Never Married 2 Ma | rried 1 (X) | | WWII 1 Yes 2 No Specify: | | | | | | | | |
| 3 ☐ Widowed 4 ☐ Divorce | d Year | or Detes: | | 1 Yes 21 No Speciny: | | | | | Specify | wn. | ite |
| 15. Deceder (Specify only higher | nt's Education | tod) | 16a. D | ecedent's Us | uel Occup | ation | t of work | ina | 16b. Kind of B | usiness/In | ndustry |
| Elementery/Secondery (0-12) | | ge (1-4 <i>o</i> r 5+) | - li | Give kind of w | | d) | 1 DI WOIN | m ny | ** | | |
| 12th | 00110 | - (| | Trai | ner | 5 10 | | | Horse | S | |
| 17. Father's Neme (First, Middle | , Last) | | | 2 () | | 18. Moth | er'a Nem | e (First, Middle | e, Meiden Suman | ne) | |
| William | Warther | 1 | | | | A ₁ b | erta | Owi | ngs | | |
| 19e. Informent's Neme/Reletion | ship (Type, Print |) | 19b. N | feiling Addres | ss (Street | | | | ber, City or Town, | State, Zij | ip Code) |
| Shirley Warthe | | | | | | | | | hington, | | |
| 20a. Method of Disposition | 0 | | | isposition (Na cremetory or | | | | Date | 20c. Location | | |
| 1 N Burial 2 □ Cremetion | | rom Stete | | | | | 1. / | 11/000 | | | |
| 4 Donetion 8 Other (| | W | | n Ceme | | | | 11/200 | | | ,Md. |
| 21. Signeture of Funeral Service | Licensee | / | | George George | nd Addre | ss of Fecili Kalas | Fun | eral H | ome, P.A | | |
| 234 Part Enter the disease of | tala | | | 6160 |)xon | hill | Rd. | Oxon H | ill. Md. | 207 | 45 |
| Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events | 5 b | buon buon | O (or as a con | nsequence of | de | 30 | is | en | _ | | 5m |
| Cause (Diseese of Injury | Due to (or as d | | | | | L | pu | Low | 2 | | 70 |
| resulting in death) Last | d | | | | | ren in Part | ew | | d tobacco una go | | 7 V |
| resulting in death) Last | d | | | | | ren in Part | Della I. | 10 | Yan 20 No | 3 Pro | obably 4□Uni |
| resulting in death) Last | d | | | | | ren in Part | <u> </u> | 1 [24a. Wa | _/ | 3 ☐ Pro | Obably 4 Unit |
| resulting in death) Last | d | | | | | ren in Part | <u> </u> | 1 [24a. Wa | Yaa 20 No | 3 Pro | obably 4 ☐ Universe autopsy finds vailable prior to |
| resulting in death) Last | d | | | | | ren in Part | <u> </u> | 1 Z4a. Wa | Yaa 20 No | 3 Pro | variable prior to ompletion of caus |
| Pert II. Other algnificant conditions to medical to med | | | | | | | | 1 Z4a. Wa | s an autopsy formed? | 3 Pro | Vere autopsy findivailable prior to ompletion of caus f death? |
| Pert II. Other algnificant conditions to medical examiner? | al Hospital | to death but not | resulting in th | ne underlying | cause giv | 26. Plac | e of Deet | 1 C 24a. Wa per 1 C 1 C Check only | s an autopsy formed? | 3 Pro | Vere autopsy findivallable prior to ompletion of caus f death? |
| Pert II. Other algnificant conditions to medical to med | al Hospitel: | to death but not | resulting in th | ne underlying | cause giv | 26. Plac | e of Deet | 24a. Wa peri | s an autopsy formed? | 3 Pro | Vere autopsy find vallable prior to ompletion of caus f death? |
| Pert II. Other algnificant conditions to medical examiner? 1 Yes 2 No 27. Manner of Deeth 1 Neturel 5 Pendi | al Hospitel: | to death but not | resulting in th | ne underlying | cause giv | 26. Plac | e of Deet | 24a. Wa peri | s an autopsy formed? Yes 25 No one) sidence 6 5 50th | 3 Pro | Vere autopsy findivallable prior to ompletion of caus f death? |
| 25. Wes case referred to medic examiner? 1 Yes 2 No 27. Manufer of Death 1 Neturel 5 Pendi invest 3 Suicide 6 Could | Hospitel: 28a. [ing tigetion dingt be 28a. [| to death but not | resulting in th | atient 3 C | cause giv | 26. Placener: 4 No | e of Deet | 24a. Wapper 1 Check only one 5 Res 28d. Describe | s an autopsy formed? Yes 25 No one) sidence 6 5 other injury occur (Street and Numi | 3 Pro | Vere autopsy findiveilable prior to ompletion of caus f death? Yes 2 No if y) Holy 2 PAVEJETA |
| 25. Wes case referred to medicine examiner? 1 Yes 2 No 27. Manner of Deeth 1 Netural 5 Pendi invest 2 Accident 5 Could | Al Hospitel: 28a. I (ling tigetion d not be mined 28e. F | to death but not | resulting in the control of the cont | atient 3 C | cause giv | 26. Placener: 4 No | e of Deet | 24a. Wapper 1 Check only one 5 Res 28d. Describe | yea 2 No s an autopsy formed? Yes 2 No one) sidence 6 Sott | 3 Pro | Vere autopsy findiveilable prior to ompletion of caus f death? Yes 2 No if y) Holy 2 PAVEJETA |
| 25. Wes case referred to medice examiner? 1 Yes 2 No 27. Manufer of Deeth 1 Neturel 5 Pendi Invest 3 Suicide 6 Could detern | Hospitel: 28a. [tigetion d not be mined 28e. [| to death but not I Inpatient 2 Dete of Injury Month, Dey Year Plece of Injury - A puilding, etc. (Spe | resulting in the | atient 3 [] [ne of only M. o., street, fectors | Cause giv | 26. Place lier: 4 N yet k? Yes 2 | e of Deet ursing Ho | 24a. Waper 1 Ch (Check only) ome 5 Res 28d. Describe 28f. Location City or To | s an autopsy formed? Yes 25 No one) sidence 6 5 Otto how injury occur (Street and Numiown, Stete) | 3 Production of Production of Specimed | Vere autopsy findivallable prior to ompletion of caus if death? Yes 2 No |
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| 25. Wes case referred to medice examiner? 1 Yes 2 No 27. Manner of Deeth 1 Neturel 5 Pendi Invest 3 Suicide 6 Could detern 29e. Certifier (Check only one) | Hospitel: 28a. [ing tigetion dinot be mined 28e. [ling Physician: Te il Examiner: On to and | to death but not Inpatient 2 Dete of Injury Month, Dey Year Delice of Injury - A building, etc. (Spe | resulting in the result | atient 3 [[] [] [] [] [] [] [] [] [] | Cause giv | 26. Place ner: 4 N N Y et K? Yes 2 One, date are pinton, dec | e of Deet ursing Ho No | 24a. Wa peri | s an autopsy formed? Yes 2DNo one) sidence 6000th how injury occur (Street and Numiown, Stete) a cause(s) and m, dete and place, | 24b. Washington of the control of th | Vere autopsy finding vallable prior to ompletion of caus f death? Yes 2 No Yes 3 No Yes 4 No |
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| 25. Wes case referred to medice examiner? 1 Yes 2 No 27. Manner of Deeth 1 Neturel 5 Pendi Invest 3 Suicide 6 Could detern 29e. Certifier (Check only one) | Hospitel: 28a. [ing tigetion dinot be mined 28e. [ling Physician: Te il Examiner: On to and | to death but not I Inpatient Dete of Injury Month, Dey Year Plece of Injury - A puilding, etc. (Spe | resulting in the result | atient 3 [[] [] [] [] [] [] [] [] [] | Cause giv | 26. Place ner: 4 N N Y et K? Yes 2 One, date are pinton, dec | e of Deet ursing Ho No | 24a. Wa peri | s an autopsy formed? Yes 2DNo one) sidence 6000th how injury occur (Street and Numiown, Stete) a cause(s) and m, dete and place, | 24b. Washington of the control of th | Vere autopsy findiveilable prior to ompletion of caus f death? Yes 2 No ify) Holy 2 PREJETA ral Route Number stated. to the cause(s) |
| 25. Wes case referred to medice examiner? 1 Yes 2 No 27. Manner of Deeth 1 Neturel 5 Pendi Invest 3 Suicide 6 Could detern 29e. Certifier (Check only one) | al Hospitel: 28a. [ing tigetion do not be mined 28e. [ling Physician: To it Examiner: On the ling Physician and ling Physici | to death but not I Inpatient Dete of Injury Month, Dey Year Plece of Injury - A puilding, etc. (Spe the basis of exammenner steled. | resulting in the property of t | atient 3 [[ne of my M M], street, fector investigation [2 | Cause giv | 26. Place ner: 4 N N Y et K? Yes 2 One, date are pinton, dec | e of Deet ursing Ho No | 24a. Wa peri | s an autopsy formed? Yes 2DNo one) sidence 6000th how injury occur (Street and Numiown, Stete) a cause(s) and m, dete and place, | 24b. Washington of the control of th | Vere autopsy find vailable prior to ompletion of caus f death? Yes 2 No ify) Home are proved to the cause f death. |
| 25. Wes case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Neturel 5 Pendi Invest 3 Suicide 4 Homicide deten 29e. Certifier (Check only one) 29b. Signafure end title of certifie | al Hospitel: ing tigetion d not be mined 28e. Filling Physician: To it Examiner: On the andier | to death but not I Inpatient Dete of Injury Month, Dey Year Plece of Injury - A pullding, etc. (Spe the basis of exammenner steled. | resulting in the property of t | atient 3 [[ne of my M M], street, fector investigation [2 | OOA Oth OOA Injur Wor 1 ony, office d at the tim n, in my o | 26. Place ner: 4 N N Y et K? Yes 2 One, date are pinton, decense number | e of Deet ursing Ho No nd place, sth occurr | 24a. Wa per 1 | s an autopsy formed? Yes 2DNo one) sidence 6000th how injury occur (Street and Numiown, Stete) a cause(s) and m, dete and place, | 24b. Washington of the control of th | Vere autopsy find vailable prior to ompletion of caus f death? Yes 2 No ify) Home are proved to the cause f death. |

DHMH 16 Ray 6/95

7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months

Days

the Meryland as filed within 72 hours effer deeth with the Merylen, trippere, in the property of thems 23s or 28s-f ehow went, the section transition transition to notified as Directo Maryland Prince George's Mount Rainier 10e. Street and Number 10f. Zip Code 3001 Queens Chapel Road #301 20712 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 1 ☐ Yes 2 ☑ No If Yes, Giva Year or Datas: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☒ No Specify: à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Musician Colmit. Pages 1 and 2 ahouid be file popartment of Health and Mental Hy (Important: if Item 27 is marked other any Injury or other traumatic event.) 17. Father's Name (First, Middle, Last) Ulysses Scott White Icey Mizzelle 19a. Informant's Name/Relationship (Type, Print) Hannah E. White - Wife 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Method of Disposition Data 1 Burial 2 ☐ Cremation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery 21. Signature of Funeral Service Licensee Jasa 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Physician tmmediata Cause (Final METASTATIC LUNG CANCER /Medical disease or condition resulting in death) Examiner CANCER sician and burlei-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Box 68760. physician the burle Physician/Medical Due to (or as a consequence of) 987 P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. Records. þ Completed of Vital Physicien: 8 25. Was case referred to medicat examiner? Hospitat 1 (Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Certification: To sid. funeral 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? Aftert or Attending Division 1 Natural 5 Pending investigation a effer des.

A Director: Afre 1 Yas 2 No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide To the Hospital o within 24 hours of To the Funerel Di completely filled in 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, end due to the cause(s) and mennar as stated.

| Medical Examiner: On the basis of examination end/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number rall Lau

NAYAK MD

32. Registrar'e Signatura

White, Sr.

68

10c. City, Town or Location

1. Decedent'e Name (First, Middle, Last)

4a Facility Name (If not institution, give street and number)

10b. County

Prince George's Hospital Center

6. Sex

1⊠M 2□ F

Ulysses Grant

246-40-8680

Usual Residence of Decedent

10a. Stata

Physician

/Medical

Examiner

Funeral

Director

Chick Hall's Surf Club 18. Mother's Nama (First, Middle, Maiden Sumame) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4005 Chesapeake Avenue, Chesapeake Beach, MD 20732 20c. Location - City or Town, Stata 01/10/00 Brentwood, Maryland 22. Name and Address of Facility
Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781 Approximate Intervel Between Onsat and Death HRONIC OBSTRUCTIVE LUNG DISEASE 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings evailabla prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yas 2 No 1 Yes 2⊠ No 26. Placa of Death (Check only ona) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 29d. Data signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6501 LANDOVER ROAD, LANDOVER MD 20785 **ORIGINAL**

2. Data of Death

8. Data of Birth (Month, Day, Year)

Aug. 7, 1931

Month

4b. City, Town, or Location of Death

Cheverly

Hours

Day

4c. County of Death

10g. Citizen of What Country?

Specify:

16b. Kind of Business/Industry

U.S.A.

Prince George's

14. Race - American Indian. Black, Whita, etc.

White

January 6, 2000

3. Time of Death

Birthplace (Stata or Foreign Country)

North Carolina

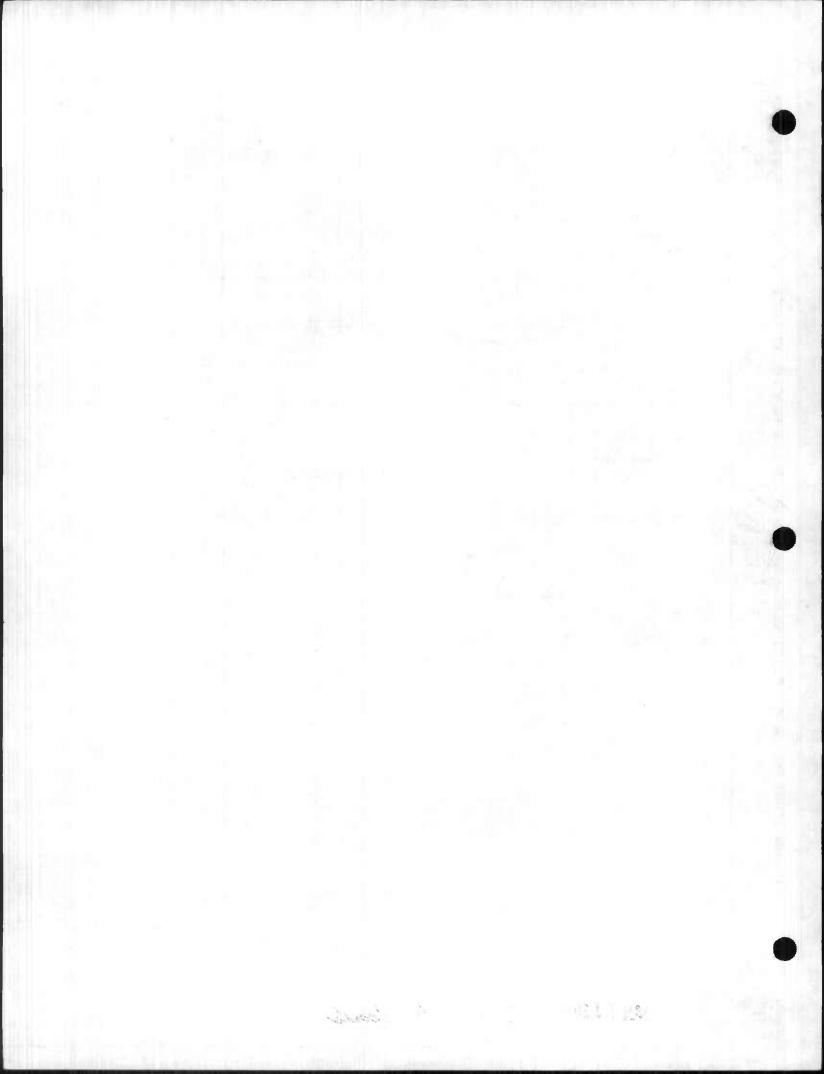
10d. Insida City Limits 1 Yas 2 No

1:00 p.m.

State Registrar

LIPISHREE

31. Date filed (Month, Day, Year)
JAN 1 1 2000



State of Maryland / Department of Health and Mental Hygiene 0 0 2 4 3 0

Certificate of Death 2. Data of Death 3. Time of Death 1. Decedent's Nama (First, Middle, Last) January 9, 2000 **Physician** 12:48am Arnold F. Watts
4a Facility Nama (If not institution, give street and number) /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner 4620 North Park Ave Unit PH5E Chevy Chase Montgomery 7. Age (In yrs. last birthday) | Wunder 1 Year | H Under 24 Hrs. | 8. Data of Birth | 1 (Month, Day, Year) | 8. 1 | Yrs. | 8. Data of Birth | 1 (Month, Day, Year) | 8. P t e m b e r 1918 9. Birthplaca (Stata or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 228-09-6724 Director Virginia Usual Rasidence of Decedent the Menyland 10a Stata 10b. County 10c. City, Town or Location 10d. tnside City Limits Itam 27 is marked other than "natural", or itema 23a or 28a-1 show other traumatic avant, the Medical Examinar must be incitived at Maryland Montgomery Chevy Chase 1 Yas 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 4620 North Park Ave Unit PH5E United States Funeral 12. Was Decedent Ever in U,S. Amed Forces? 1 Et Yes 2 □ No If Yes, Give 1 9 4 0 − 4 5 Year or Dates! Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14 Race - American Indian Black, Whita, etc. 72 hours after 1 Nevar Married 2 Merried permit. Pages 1 and 2 should be filed within 72 hours aft. Department of Health and Mental Hygiene. Important: if tam 27 is marked other than "natural; or it any Injury or other traumatic avant Baitimore, Maryland 21215-0020 1 Yes 2 No Specify: SpecifyWhite by 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elemantary/Secondary (0-12) College (1-4or 5+) Women's Wear Retailer 18. Mothar's Name (First, Middle, Meiden Sumama) 17. Father's Nema (First, Middle, Last) Celia Goodman Robert Watts 19a. Informant'a Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Doris Watts/Wife 4620 N. Park Ave Unit PH5E Chevy Chase MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 1 Pate 1 1 20c. Location - City or Town, Stata 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State King David Memorial 2000 Falls Church, VA 4 Donation 5 Other (Specify) 22. Name and Address of Facility Takoma Funeral Home 21. Signature of Emeral Service Licensee 254 Carroll St. NW Washington, DC 20012 23a Part1. Epter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** /Medical Immediata Causa (Finat diseasa or condition resulting in death) Reunl FAILM Examiner Sequentially list conditions, if any, laading to immediata cause. Enter Underlying Cause (Disease or thjury that initieted eventa rasulting in death) Last Due to (or as a consequence of) attending physician for use as the burie P.O. Box 68760, Physician/Medical Due to (or as a consequence of): Part It. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yaa 2 No 3 Probably 4 Unknown Batenrosclenohe Records, 24b. Wera autopsy findings available prior to completion of cause of death? Completed 24e. Was an autopsy performed? 1 Yas 2 No 1 Yas 20 No Division of Vitai To the Hospital or Attanding Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be 25. Was case reterred to medical examiner? 26. Placa of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpetient 3 | DOA Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) 1 Yas 2 No Medical Certification: To 27. Mannar of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural
2 Accident 5 Pending 1 Yes 2 No investigation 3 ☐ Suicide 6 Could not be 28f. Location (Street and Number or Rural Routa Number, City or Town, Stele) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signatura and title of commo 29c. License number 29d. Data signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wisconsin Ave, C.C. MD20815 -15 ITER 5530 31. Data filed (Month, Day, Year) 32. Registrar's Signature JAN 1 0 2000 Registrar

DHMH 16 Ray 6/95

State Registrar 30. Name end eddress of person

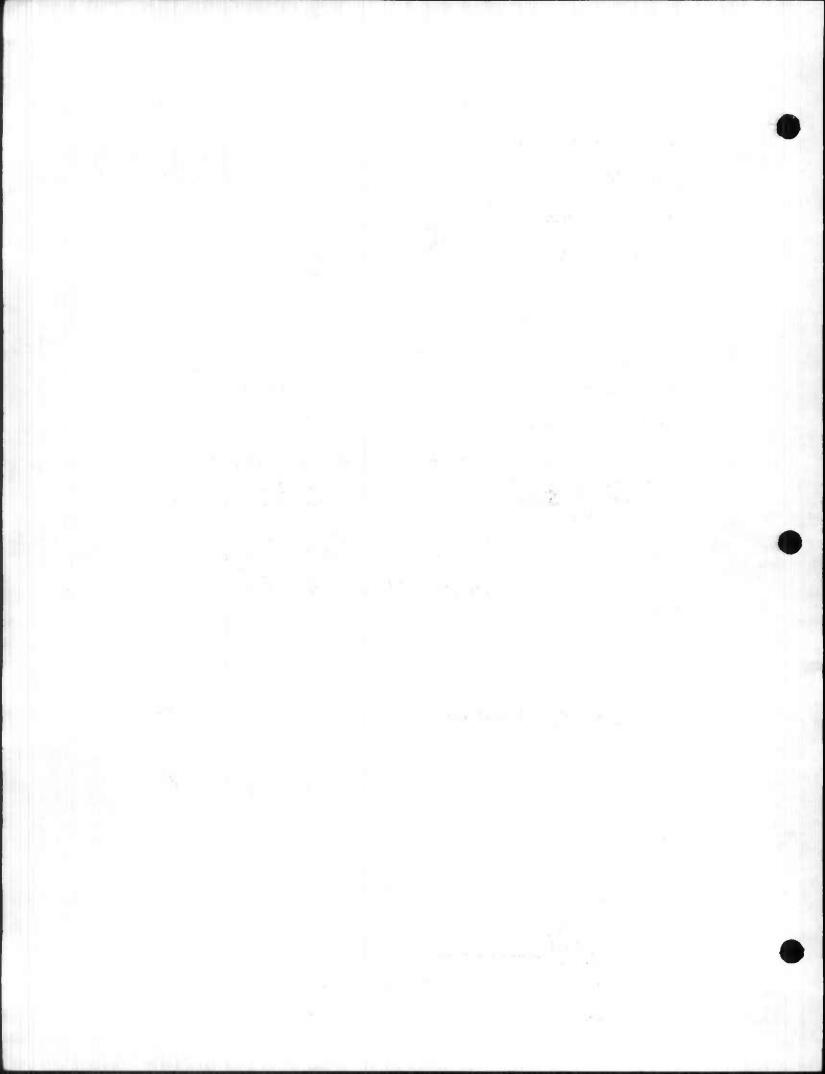
Robert A. Gorlaski, MD

31. Dete filed (Month, Dey, Yeer) 32. Registrar's Signeture

who completed cause of deeth (Item 23e) (Type, Print)

A. Jank

311 N. Fourth St., oakland, Maryland 21550



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

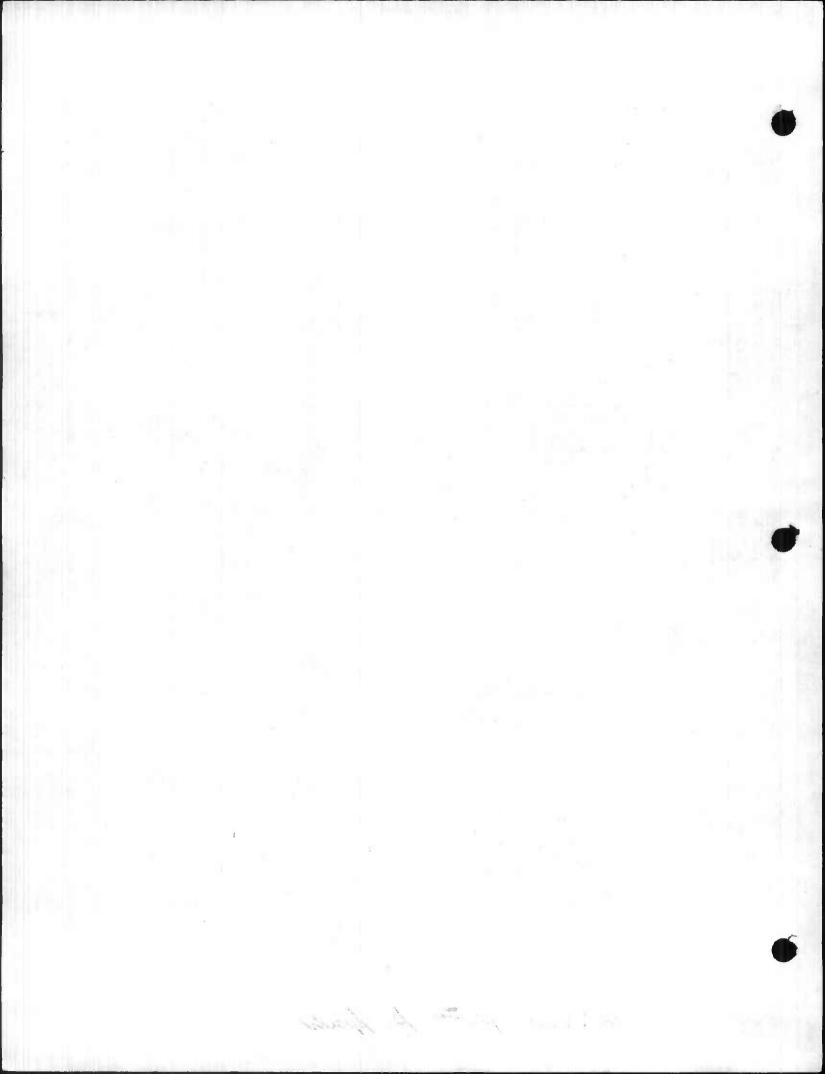
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death January 7, 2000 **Physician** Sherea Wisner 5:36 pm /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner Frederick Memorial Hospital Frederick Frederick | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Apr. 17, 1930 7. Age (In yrs. last birthday) 69 Yrs Birthplace (State or Foreign Country) **Funeral** Maryland 220-26-0210 Director Usual Residence of Decedent death with the Maryland 10h. County 10c. City, Town or Location ahow 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 Yes 2 No Director Maryland Frederick Union Bridge 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 12801 Bunker Hill Rd. 21791 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 ahouid be filed within 72 hours after of Department of Health and Mental Hygiene. Important: if Nem 27 Ia marked other than "natural, or Nem any Injury or other traumatic event, the Medical Franchis Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baitimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11 office manager underwriters/insurance 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Clyde McClellan Young Irene Winpigler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) A. Eugene Wisner/ husband 12801 Bunker HI11 Rd. Union Bridge, MD 21791 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ₺ Burial 2 ☐ Cremation 3 ☐ Removal from State Resthaven Mem. Gardens 1/11/00 Frederick, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Hartzler Funeral Home 21. Signature of Fyneral Service License 404 S. Main St. Woodsboro, MD 21798 23a. Part1. Enter the disease, or complications that ceused the shock, or heart failure. List only one cause on each line. Approximate Intervat Between Onset and Death **Physician** /Medical Immediate Cause (Final - weeks disease or condition resulting in death) neumpma Examiner Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit the death certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): 68760 Physician/Medical that initiated events resulting in death) Last Due to (or as a consequence of): 8 Box P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 10 708 2 No 3 Probably 4 Unknown Ohs tricetive Records. à 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy 1 Yes 2 No 1 Yes of Vital Hospital or Attanding Physician: 24 hours after death. 25. Was case referred to medical axaminer? e 26. Place of Death (Check only one) Hospital: 2 ER/Outpatient 3 DOA 1 Yes 22 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To this 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Division 1 Natural 5 Pending investigation after death.

Director: Aft
d in by the fur 1 Yes 2 10 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, atreet, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide To the Hospital within 24 hours a To the Funeral Completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of confin 00 D07186 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Philip Shapiro 31. Date filed (Month, Day, Year) 814 Toll House Ave. Frederick, MD 21701 32. Registrar'a Signature State Registrar

DHMH 16 Ray 6/95

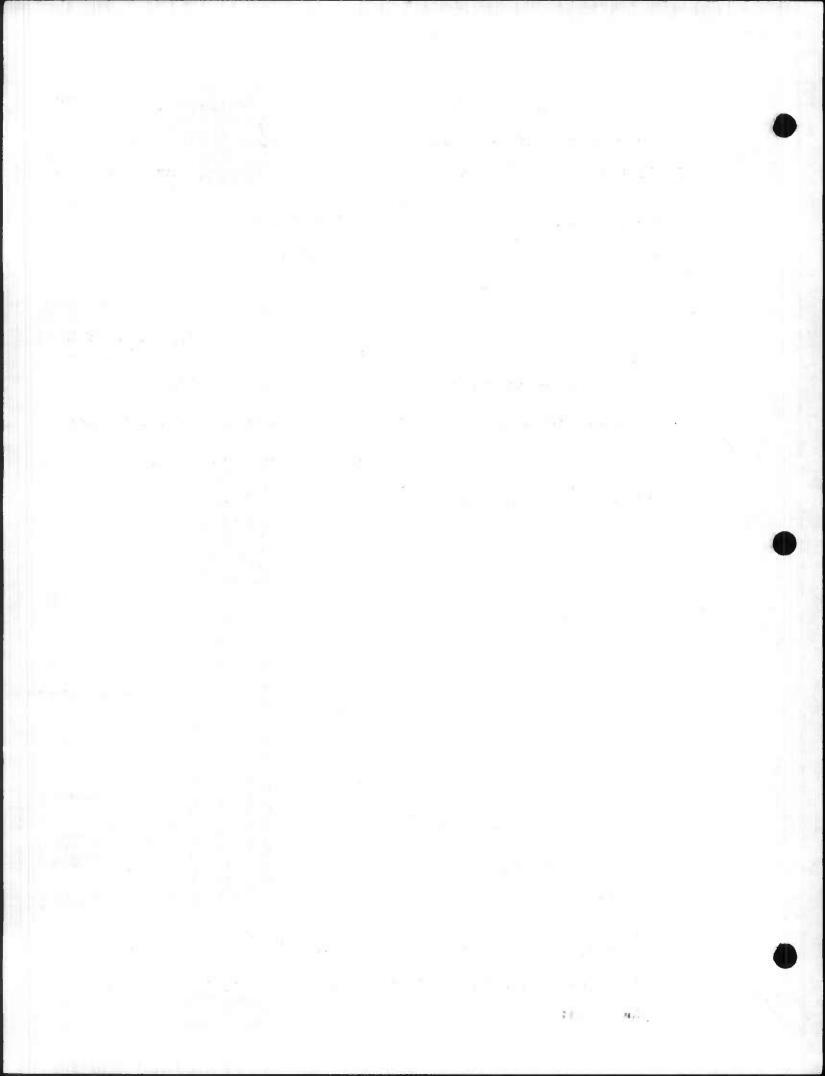
JAN 1 1 2000



State of Maryland / Department of Health and Mental Hygiene

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| | | | | | | C | ertificati | e or | Death | | | Reg. No. | - | 06700 | |
|-------------------|---|-------------------|--|---|--|------------------------------|---|------------------------------|--------------------------|-------------------------------------|---|--|--|---|--|
| | Physic /Medi | | Drenda kay ward | | | | | | | • | 2. Data of Do Month Janua: | Day | 3. Time of Death 2000 | | |
| | Exami | | 4- 5 114- 14 | | | | | | | wn, or Lo | ocation of Dea | Death 4c. County of Death Cecil | | | |
| | Funeral Director | | 5. Social Security Number 215–42–1776 | 6. Sax 1 □ M 2 XF | | | | | 24 Hrs. | 8. Data of Bi (Month, D May 3 | | 9. Birthp | iaca (Stata or Foreign stry) aryland | | |
| | Aaryland I show | ō | Usuai Rasidance of Decedant 10a. Stata 10b. Count Maryland C | ecil | 10c. (| City, Town or | Location | D. | D. | | _ | | 1 | 0d. Inside City Limits | |
| | with the A n or 28a- | Director | 10e. Street and Number 63 Robin Drive | | | 10f. Zip | | ort De 2190 | | L | 10g. Citizan of What Country? U.S.A. | | | | |
| 020 | 72 hours after deeth with the Maryland natural, or items 23a or 28a-f show dreal Examiner must be notified at | by Funeral | 11. Maritai Status 1 Navar Married 2 Ma 3 Widowed 4 Divorce | cedant Evar in orcas? 2(1) No ive | U,S. 13 | B. Was Deced if Yas, spec | | Hispanic Ori pan, Maxicai | igin? (Sp. n, Puarto | ecify Yas or N Rican, atc.) | | ce - Amaric ck, Whita, | an indian, | | |
| 21215-0020 | within ene. than | Completed | 15. Deceda (Specify only high) Elementery/Secondary (0-12) Twelve Years | nt's Education ast grada completed, Collaga |) (1-4or 5+) | /Gin | edant's Usua ra kind of wor DO NOT us Diet | k dona e retire | during mos d) | it of work | ing | 18b. Kind of Bueinaes/Industry Cecil Co. Board of Fd Elkton, Maryland Middla. Maidan Sumama) | | | |
| Maryland | S d ai S | To Be (| 17. Fathar's Nama (First, Middla Ge | orge Robe | rt Sewe | e11 | | | 18. Moth | | | a. <i>Maid</i> an Su <i>m</i> ar e Chadwi | | | |
| | nd 2 alth ar 27 is r trau | | 19a. Informant's Neme/Ralation Harold J. Ward | | | | Robin I | riv | | | eposit | , Maryla | ind 2 | 21904 | |
| Baltimore, | t. Pages tment of tant: If it | | 20a. Mathod of Disposition 1 X virial 2 Cramation 4 Donetion 5 Other (| Specify) | Stata | West No | amatory or or ottingl | thar pla nam | Cemet | | Data /18/00 | Co.lora | , | | |
| Bal | parmit. Departn Imports any injt | | 21. Signature of Funarai Sarvice | M. tale | ELDON | Sr. I | errvvi | Pat | terso | n & vlan | d 2190 | neral Ho 03-0766 | ome | | |
| | Physician /Medical Examiner | er | 23a. Part1. Entar tha disaasa, o shock, or haart failura. Lis immediete Cause (Final disaasa or condition resulting in daath) | | Int | | nere | , | 1 | cardiac (| or raspiratory | arrast, | | Approximata intarvai Batween Onsat and Death | |
| ox 68760, | certificate be executed nding physician and use as the buriel-transit | VMedical Examiner | Sequentially list conditions, if any, leading to immediate cause. Entar Undarlying Cause (Disease or injury that initiated events rasulting in death) Last | 6 | 1 40 | (or as a cons | At | tn | 2 01 | cle | vou | di | ea 2 | e | |
| P.O. B | requires that the death is seen signed by the etten hould be detached for u | Physician | Part II. Other significant conditi | lons contributing to d | leath but not re | asulting In tha | undarlying ci | ausa gi | van in Part i | i. | 23b. Did tobacco use contributa to the cause of | | | | |
| of Vital Records, | 2 S S | Completed by | | | | | | | | | 24a. Was | s an autopsy ormed? | av | ere autopsy findings allable prior to mpletion of causa death? | |
| ital B | t es e | Be Con | 25. Was casa referred to medical | ai | | | | | 28. Place | a of Deat | 1 🗆 | Yas 2/Q(No | 10 | Yas 2 No | |
| † | O W | 70 | examiner? 1 ☐ Yas 2 ☒ No | Hospitai: | Inpatient 2 | ☐ ER/Outpati | ent 3 DO | A Ot | har: 4 Nu | ursing Ho | ma 5□Res | Idance 8 Oth | har (Specif | y) | |
| Division o | After fune | Certification: | E L Trootsaire | ing (Mor | | 28b. Tima | | 8c. inju Wo 1 □ | nyat ork?]Yas 2 □ | | 28d. Dascribe | how injury occur | rred | | |
| DIV | 는 전투 호 | | 3 Suicida 6 Could 4 Homicida daterr | nined 28a. Flac | e of injury - At ling, atc. <i>(Spe</i> | | streat, factory | , office | | | 28f. Location City or To | (Street and Numi own, Stata) | ber or Rure | I Routa Number, | |
| | the Hospital in 24 hours the Funeral hpietely filled | ledical | | | | | | | | | and dua to the ed at tha tima | , data and piace, | and due to | the cause(s) | |
| | | 2 | | | | | | | | | | 29d. Data signe | Month, | Day, Year) | |
| | 8 | | 30. Nama and eddress of person Madhu S. Sachd | | | | | nue | , Nor | th E | ast, Ma | aryland | 2190 |)1 | |
| | Sta Registr | _ | JAN 1 8 20 | | Registrar's Sig | neture | Spor | (s) | 1 | | | | | | |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Data of Death 3. Tima of Death Month Jan Williams **Physician** Claudia Kay 05 2:00 PM 2000 /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street and number) 4c. County of Death Examiner Bartimore City University of Maryland N/A 5. Social Security Number 7. Age (In yrs. last birthday) Birthplaca (Stata or Foreign Country) **Funeral** 1 M 2 N F Yrs. 219-55-9187 Director 1999 Maryland Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 ☐ Yas X No Directo Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? b 132 Dumbarton Drive 21403 harra 23a USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No If Yes, Give Year or Dates: 11 Marital Status 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian. Black, Whita, atc. 1 Never Married 2 Married Saltimore, Maryland 21215-0020 natural, or 1 ☐ Yes 2 No Specify: Specify: White by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grada completed) permit. Pages 1 and 2 should be filed within Department of Health and Mantal Hygiens important if flees 72 is marked other than 'n any injury or other traument. College (1-4or 5+) Elementary/Secondary (0-12) N/A N/A 17. Fathar's Nama (First, Middla, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be Ty J. Marquess Amanda Kav Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Amanda Kay Williams/ Mother 132 Dumbarton Dr. Annapolis, MD 21403 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cematary, crematory or other place) 20c. Location - City or Town, State XXBurial 2 ☐ Cremation 3 ☐ Removel from Stete Baldwin Mem'l. Ch. Cem. 1-7-00 4 ☐ Donation 5 ☐ Other (Specify) Millersville, MD 21. Signature of Funeral Service Licensee 22. Nema and Addrass of Fecility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximate Intarval Between Onsat and Death **Physician** acute renal failures /Medical Immediata Causa (Final disease or condition rasulting in death) 3 days Examiner heart failure Examine 3 mo physician and s the burial-transit that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last ymphanquectasis 3 MO Box 68760. Physician/Medical Dua to (or as a consequence of): great arteries transposition Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown operative transposition repair Completed by 24b. Wara autopsy findings available prior to complation of cause of death? 24a. Was an autopsy performed? Sepsis, on amphotericin multiple episodes bacterial gosis 1 Yes 1 ☐ Yas 2 ☐ No Division of Vitai 25. Was casa ratarred to medical axaminar? edical Certification: To Be 26. Place of Deeth (Check only one) 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) this 28a. Date of Injury (Month, Day Year) To the Hospital or Attanding Ph within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending invastigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 28f. Location (Street and Number or Rurel Route Number, City or Town, Stele) 6 Could not be detarmined 3 ☐ Suicida 28a. Place of Injury - At home, tarm, street, tectory, office building, etc. (Specify) 4 Homicide

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Auce D - Holleman Hckerman

2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted. 29c. License number 29d. Date signed (Month, Day, Year)

actermon

Greene St Balt. Md 21201

31. Date tiled (Month, Day, Year) State Registrar

29a. Cartifier

(Check only one)

29b. Signetura and title of certifie

JAN 0 6 2000

32. Registrar's Signatura

10 Certifying Physician: To tha best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and manner as stated.

See Interest to the second

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Physician 4:38 am SOPHIA WALLACE JAN. 4 2000 /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FAIRFIELD NURSING HOME CROWNSVILLE ANNE ARUNDEL If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 10M 28 F Director 218-24-3799 13 1904 MARYLAND Usual Residence of Decedent the Maryland 10s. Stata r than "natural", or items 23s or 28s-f ahow the Madical Examiner must be notified at 10b. Counts 10c. City. Town or Location 10d. Inside City Limits XX Yes 2□ No Director MARYLAND ANNE ARUNDEL ANNAPOLIS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funerel 3A HERITAGE COURT death 21401 USA 12. Wes Decedent Ever in U,S.
Armed Forces?
1 ☐ Yes 2 ☐ XNo
If Yes, Give
Yeer or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married 21215-0020 1 Yas 2 No Specify: Specify: BLACK à 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h. Kind of Business/Industry Pages 1 and 2 should be filled within nent of Haelth and Mental Hyglene. Int: If Item 27 is marked other then irry or other traumatic event, in Mental traum Elementary/Secondary (0-12) College (1-4or 5+) DOMESTIC OUT OF THE HOME 17. Father's Name (First, Middle, Last) Baltlmore, Maryland 18. Mother's Nama (First, Middle, Maiden Sumame) Be WALSH EASTON UNOBTAINABLE MARY ELLEN 19a. Informant's Neme/Raletionship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3A HERITAGE CT. ANNAPOLIS, MD. 21401
Disposition (Name of Date 20c. Location - City or Town, State SHIRLEY SAVOY (GRANDAUGHTER) 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 1 Suriai 2 Cremetion 3 Removel from Stete permit. Page Department of Important: If any Injury or page. 1/10/2000 DRURY, MD. 4 Donation 5 Other (Specify) MOSES CEMETERY 21. Signature of Funerei Service Licensee 22. Name end Address of Fecility WM. REESE & SONS MORTUARY, P.A. 7 arry eesa 821 WEST ST ANNAPOLIS MD . 21401 Approximate tenter the mode of dying, such as cardiac or respiratory arrest. 23a. Pert1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line. Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Exeminer sician and buriel-transit The law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last physician s the buriel Box 68760. Physician/Medical Due to (or as a consequence of). 80 980 signed by the a 23b. Did tobacco use contribute to the cause of death? P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Records, à 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? page 2 certificate 2□No 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: director. 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 No 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA thia funeral 28a. Dete of Injury (Month, Dey Year) 27. Manyrer of Death 28h Time of 28d, Describe how injury occurred 28c. Injury at Work? After 1 Natural 5 Pending n 24 hours after death.

e Funeral Director: Afti 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, lectory, office building, etc. (Specify) 4 Homicide Hospital 29a. Certifier edical 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, data and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or Investigation, in my opinion, deeth occurred at the time, data and place, and due to the cause(s) end manner stated. (Check only one) To the Vithin 2 29c. Liceose number 29b. Signature arithm 29d. Date signed (Monthy Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

Elmo Gayoso, MD

1600 Wilkens Avenue,

Baltimore, MD

21223

se of death (item 23a) (Type Lint)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMEND: #10e mcg 1/13/00 AACO HEALTH Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death WELLS **Physician** 00 /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner Annopolis Car H Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) If Under 1 Yeer 5. Sociel Security Number 7. Age (In vrs. last birthday) **Funeral** Deys t☑M 2□F Months Director 214-05-0592 SEPT. 1905 MARYLAND Usuel Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d, Inside City Limits 1 N Yes 2 No 288-1 MARYLAND ANNE ARUNDEL ANNAPOLIS 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Dir ð must be Nerns 23a Funeral 701 GLENWOOD ST. APT 21401 420 USA 11. Merital Stetus 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Bleck, White, etc. 1 ☐ Yes 2 X No If Yes, Give Yeer or Dates: 1 Never Merried 2 Merried altimore, Maryland 21215-0020 ò 1 Yes 2 No Specify: BLACK þ 3□Widowed 4□Divorced natural 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) NORMAN BELL 17. Father's Neme (First, Middle, Lest) LABORER 18. Mother's Neme (First, Middle, Maiden Sumame) Be h and Mental h 2 SAMUEL WELLS HENRIETTA TAYLOR 19a. Informant's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) VIOLA BROWN (DAUGHTER) 63 SPA ROAD ANNAPOLIS, MD. 21401 mportant: If Item 27 20b. Plece of Disposition (Name of cemetery, crematory or other place) Pages 1 20a. Method of Disposition 20c. Location - City or Town, State to 1 DBurial 2 Cremation 3 Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) ANNAPOLIS MEM. GARDENS 1/12/2000 ANNAPOLIS, MD. 21 Signeture of Funeral Service Licenses 22. Neme end Address of Facility WM. REESE & SONS MORTUARY, P.A. any MD. 21401 Approximete 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the shock, or heart feilure. List only one cause on each line. ST es cardiac or respiratory arrest Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Fine) disease or condition resulting in deeth) Examine Examiner Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Last pue Box 68760, Completed by Physician/Medical Due to (or es e consequence of): P.O. Pert It. Other significant conditions confributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Jus With Con 1 Yee No C 3 Probably 4 Unknown Division of Vital Records. 24b. Were autopsy findings available prior to completion of cause of death? Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was cese referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this ro the Hospital or Attending Pt within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of tnjury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 10 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, and due to the cause(s) end manner as stated.
2 Medicat Examiner: On the desis of examination end/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) and grainer stated. 29e. Certifier edicai (Check only one)

State Registrar 31. Dete filed (Month, Dey, Year)

29b. Signeture and title of certifier

32. Registrer's Signeture

600 ROGERY

29d Date signed (Month, Day, Year)

France M. Henrie

JAM 1 3 2000

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth Month **Physician** Francis Xavier Wilson 2000 5:00 PM January 11 /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolls

Hours Min. 8. Date of Birth
(Month, Dey, Ye)
Dec. 2, 1 Annapolis Anne Arundel If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Deys Months 1XM 2□ F Director 187-16-3004 79 1920 Pennsylvania Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Anne Arundel Annapolis 10e Street and Number 10g. Citizen of What Country? 10f. Zip Code 965 Bent Tree Way 21401 USA Funeral Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian. 11 Merital Status Black, White, etc. filed within 72 hours after 1 XYes 2 No If Yes, Give 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: þ Year or Dates: WW 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) Cotlege (1-4or 5+) permit. Pages 1 and 2 should be filled wit Department of fleath and Mental hygient Important: If flem 27 ie marked other tha any fulury or other treumatic event, the I pages. 12 Equipment Operator Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be James Wilson Nora Mahoney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Robert F. Wilson, Sr. / 34 Austin Dr. Son Edgewater, MD 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 □ Othar (Specify) Lakemont Mem. Gardens 1-15-00 Davidsonville, MD. 22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 21. Signature of Funeral Service Licensee 147 Duke of Gloucester St. Annapolis, MD 21401 421 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata tnterval Between Onset end Deeth Physician /Medical Immediate Cause (Final disease or condition rasulting in death) ndrone Examiner -es p11 Dua to (or as a consequence of): Examiner physicien and the burial-transit umonia that the deeth certificate be executed Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical Due to (or es a consequenca of): P.O. Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? á 1 Yes 2 No 3 Probably 4 Unknown signed b Records, þ requires 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy performed? completion of cause of death? The law page 2 2 2 No SOMO 1 Yes certificate Division of Vital Attending Physician: 25. Wes case referred to medicat examiner? Be 26. Place of Death (Check only one) 200 NO Hospital: Other: 4 Nursing Home 5 Rasidence 6 Other (Specify) 1) Inpatient Certification: To 1 ☐ Yes 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After Natural 5 Pending investigation death. 1 Yes 2 No 2 Accident after death Director: 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, office building, atc. (Specify) 24 hours after to Funeral Directory pletely filled in b 4 Homicida 6 Hospital Sertifying Physician: To the best of my knowledga, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier To the Hosp within 24 ho To the Fune completely fi (Check only one) 29b. Signature and pro of certifier 29c. License number 29d. Data signed (Month, Day, Year) 00 nd address of perg who completed causa of death (Item 23a) (Type, tran 31. Date tiled (MAN) 32 Registrar's Signature State mer Registrar

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2 Date of Death 3. Time of Death 12,2000 Kristina LaTonya Anderson-Williams anuary 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Cheverly Prince George's Prince George's Hospital Center 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 8. Dete of Birth (Month, Day, Year) 8-9-1973 Birthplace (State or Foreign Country) 1 M 2 XF Months Deys Hours Min 26 212-23-2030 Yrs. Virginia Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits Maryland Prince George's District Heights tXXYes 2 □ No 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number 6817 Atwood Street, # 3 20747 U.S.A 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Rece - American Indien, Black, White, etc. 11. Maritai Status 1 Never Married 2 Married Black 1 Yes 2 No Specify: 3 Widowed 4 Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry Elementary/Secondary (0-12) 12th College (1-4or 5+) Medical Claim Processor Private 18. Mother's Name (First, Middle, Meiden Sumame) 17. Father's Name (First, Middle, Last) Jesse Edward Anderson Brenda Vines 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6817 Atwood Street, # 3 District Heights MD₂₀₇₄₇ Melvin Williams/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Forest Hills Memorial Gardens 1-18-00 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremetion 3 □ Removal from State Clinton, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility J.B. 7474 Landover Road Landover MD 20785 Jenkins Funeral Home 23a. Part1. Entof the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death Immediate Cause (Final disease or condition resulting In death) as e consequence of): h'S h ancrea Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or es a consequence of): Due to (or es a consequence of): Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of deeth? 1 Yee 2 No 3 Probably 4 Unknown ramponade arcliac 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? HIV 1 Yes 20 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Dipatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Menner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending

requires that the death certificate be executed physician and the burial-transit Division of Vital Records, P.O. Box 68760, 69 use page 2 s certificate has or Attending Physician: director,

Physician

/Medical Examiner

Examiner

Physician/Medical

þ

Completed

Be

To

Certification:

2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

After this funeral 3

Physician

/Medical

Examiner

Directo

Funeral

by

Completed

Be

Funeral

Director

7 is marked other than "natural", or flems 23s or 28s-4 show traumatic event, the Modical Examinar must be notified as

with the Maryland

24 hours after death. filled in

edical completely within 2

Hospital

State Registrar

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29b. Signature and title of certifier

investigation

6 Could not be determined

29c. License number

Hosp-

Certifying Phyelcian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated.

Georg

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year) 00

Chevery

281. Location (Street and Number or Rural Route Number, City or Town, State)

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print)

cabelle Hornia Takce

31. Date filed (Month, Day, Year) JAN 1 4 2000 32. Registrar's Signature

Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Name (First, Middle, Last) 2. Data of Death 3. Time of Death January 5, 2000 ar **Physician** Erna Wallach 3:20am /Medical 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Silver Spring Charter House Montgomery If Under 1 Yaar | If Undar 24 Hrs. | 8. Data of Birth April 1, 1919 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country)
 Unknown **Funeral** Months Days Hours 147-32-2924 10 M 20 F 80 Yrs. Director Usual Rasidence of Decedant 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or itema 23a or 28a-f show the Medical Examiner must be notified at Montgomery Silver Spring 1 Yes 2 No Director Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1316 Fenwick Lane 20910 United States Funeral death 12. Was Decedent Evar in U,S. Armed Forces? 1 Yes 2 No If Yas, Giva 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, Black, Whita, etc. filed within 72 hours after 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: Specify: White p 3₺ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other treumstic event, the Many injury or other treumstic event, the Many injury or other treumstic event, the Many injury or other treumstic Etamantary/Secondary (0-12) Collega (1-4or 5+) Homemaker Own Home 12 17. Fathar's Name (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maiden Sumame) Be Unknown "Rothenberg" Unknown 19a. Informant's Name/Ratationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Mark Strauss/Nephew 332 Zepp Road Maurertown, VA 22644 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State 1 /9 Burial 2 Cremation 3 Removal from State King David Memorial 4 Donation 5 Other (Specify) 2000 Falls Church, VA 22. Name and Address of Facility Takoma Funeral Home Get Funeral Service License e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
List only one cause on each line. 20012 Approximate Interval Between Onset and Death Physician 1. Liver with Metastese /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner Sequentially list conditions if any, leading to immediat cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): P.O. Box 68760 Physician/Medical 2 Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes NO No 3 Probably 4 Unknown Records, py 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy BELLO certificate 1□Yes 2□ No of Vital 88 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 5 Residence 6 Other (Specify) Certification: To 1 Yes 82 No 書 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? After Division Attending 1 Solatural 5 Pending 1 Yes 2 No death. 2 ☐ Accident investigation Hospital or Atland 24 hours after death Funeral Director: 3 Suicide 5 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital
within 24 hours a
To the Funeral C
completely tilled 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Cartifler 29b. Signature and title of certifies 28c Licansa number 29d. Data signed (Month, Day, Year) 100000232 30. Name and addrass of person who completed causa of death (Item 23a) (Type, Print)

Registrar

DHMH 16 Rev 6/95

31. Data filed (Month, Day, Year)

JAN 1 0 2000

1299- LAMBERTON Du Sluer Sprin Actschuler MD. 32_Registrar's Signatura

Charge & Hard 1905 of MAI

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene (1) (1) (1)

| | Certificate of Death | Re | g. No. | 12990 | | | | | | |
|--|--|---|---|--|--|--|--|--|--|--|
| Physician | 1. Decedant's Name (First, Middla, Last) | 2. Data of Death Month | | 3. Time of Death | | | | | | |
| /Medical | GEORGE WESTON J | AN. 13 | 2000 Year | 1006 | | | | | | |
| Examiner | 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Lo | cation of Death | 4c. County of Deat | h | | | | | | |
| | ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS | | ANNE ARUI | NDEL | | | | | | |
| Funeral | 5. Social Security Number 6. Sex 1√C M 2 □ F 7. Aga (In yrs. last birthday) 1√c Months Days Hours Min. | 8. Data of Birth (Month, Day, | Year) 9. Birt | hplace (State or Foreignatry) | | | | | | |
| Director | 251-22-3006 | JAN. 3 | 1925 S. | CAROLINA | | | | | | |
| P & | Usuat Rasidence of Decedant 10a. Stata 10b. County 10c. City, Town or Location | | | 10d. Inside City Limits | | | | | | |
| sho sho | Tot. Oldy, Town or Escalion | | | 120 Yas 2 No | | | | | | |
| vith the Me or 28a-f s be notified Director | MARYLAND ANNE ARUNDEL ANNAPOLIS | | | | | | | | | |
| Dir. | 10e. Street and Number 10f. Zip Code | 10 | og. Citizen of Whet Co | ountry? | | | | | | |
| ath v | 409 OAKLAWN AVENUE 21401 | | USA | | | | | | | |
| 72 hours after death with the Meryland natural; or theme 23a or 28e-1 show steal Examiner must be notified at steel by Funeral Director | 11. Merital Status 1 Never Merried 2 Married 1 Never Merried 2 Married 3 Widowed 4 Divorced 12. Was Decedent Evar in U,S. Armset Forces? 1 Never Merried 2 Narried 13. Was Decedent of Hispanic Origin? (Spe If Yas, specify Cuban, Mexican, Puerto If Yas, Specify: 1 Yes, Giva Yaer or Datas: 1946-48 | Rican, atc.) | 14. Race - Ama Black, White Specify: B | | | | | | | |
| ed within 72 hours ygiene. wr than "natural", ft, tra than ell Ers ft, tra than Ers ft. | 15. Decedent's Education 16a. Decedent's Usual Occupation | 1 | 6b. Kind of Business/ | Industry | | | | | | |
| c | (Specify only highest grada completed) [Give kind of work dona during most of working into the complete of th | ng | | | | | | | | |
| filed within Hygiene. ther then em, to be Comple | 12th 0 CUSTODIAN | | US NAVAL | ACADEMY | | | | | | |
| 三工艺艺 8 | 17. Father's Nema (First, Middla, Last) 18. Mother's Nema | | | | | | | | | |
| Vade o | ALLEN WESTON JULIA | GREEN | | | | | | | | |
| A DEE | 19a. Informant's Name/Ralationship (Type, Print) 19b. Melling Address (Street and Number or Rura | | City or Town, Stata, 2 | Zip Code) | | | | | | |
| DENE | ELEANOR WESTON (WIFE) 409 OAKLAWN AVE. AN | NAPOLI | S, MD. 2 | 1401 | | | | | | |
| ーエンセ | 20e. Method of Disposition 20b. Place of Disposition (Name of | | 20c. Location - City or | | | | | | | |
| 00. | XIXMirial 2 □ Cramation 3 □ Removal from Steta 4 □ Donation 5 □ Other (Specify) MADVIAND VIENDANI | | | | | | | | | |
| nit. Pa antmen ortant: injury | 21. Signature of Funeral Service Licensea 22. Nama and Addrass of Facility | 19/200 | O CROWNS | VILLE, M | | | | | | |
| permit. Pag Department: Important: If any injury o | Harry D. Leese WM. REESE & SONS | MORTUA | RY. P.A. | | | | | | | |
| | 23a. Part 1. Enter the disaesa, or complications that causad the death. Do not enter the mode of dying, such as cardiac of shock, or heart failura. List only ona cause on each line. | IAPOLIS | . MD. 21 | 401 | | | | | | |
| Examiner unand una | disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): | | 1 | | | | | | | |
| ifficate be ng physicia es the bur Aedical | Cause (Disease or injury that initialed events rasulting in death) Last Dua to (or es a consequence of): | | | | | | | | | |
| of the death cer d by the ettendin eteched for use Physician/N | d | | | | | | | | | |
| sic sic | Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. | 23b. Did tol | 23b. Did tobacco usa contributa to the causa of d | | | | | | | |
| 5 60 | Esophageal career | 1 🗆 Ye | 2 No 3 P | robably 4 Unkn | | | | | | |
| 2 8 M D | | 24a. Was ar perform | ned? | Wara autopsy finding available prior to complation of cause of death? | | | | | | |
| The la | | 1 ☐ Ye | s 200 No | 1 □ Yes 28 No | | | | | | |
| certificate rector, pag | 25. Was casa raferred to medical axaminar? | (Check only one | a) | | | | | | | |
| 000 | Hospital (Other) | me 5 🗆 Reside | nce 6 Other (Spe | city) | | | | | | |
| After After Ing | Netural 5 Pending (Month, Day Year) Injury Work? 2 Accident investigation M 1 Yes 2 No | 28d. Describe ho | w injury occurred | | | | | | | |
| To the Property of Attenting Property of the Puneral Director: After to completely filled in by the funeral Medical Certification: | 4 ☐ Homicide building, afc. (Specify) | City or Town | | | | | | | | |
| n 24 houns Funer pletely fill edical | 29a. Certifier (Check only one) Certifying Phyaician: To the best of my knowledga, death occurred at the time, date and place, a constant of my knowledga, death occurred at the time, date and place, a constant occurred and manner stated. | and due to the ca ed at tha tima, da | use(s) and manner as its and place, and due | s stated. a to the cause(s) | | | | | | |
| Me Within | 29b. Signatura end Jitte of certifiar 29c. License number | 29 | d. Data signed (Mont | th, Day, Year) | | | | | | |
| ->-0 | Decient | | 1/13/00 | | | | | | | |
| | 1000 18 T | | 1/(3/00 | | | | | | | |
| | 30. Nama and address of person who completed cause of death (Item 23a) (Type, Print) | MIN | 21401 | | | | | | | |
| | 11 Date fled (Month Day You) | TIV | 6170 | | | | | | | |
| State Registrar | 31. Data filed (Month, Day, Year) 100 1 8 2000 32. Registrar's Signetura | | | | | | | | | |

A Second to the
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Tsai-Yung C. Month 01 Physician Yang 01 2000 7:50 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Millennium Health Care Center Edgewater Anne Arunde1 | If Under 24 Hrs. | 8. Dete of Birth | Hours | Min. | 12/08/1915 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) China **Funeral** Deys Months 1 M 2 XF 84 224 39 7776 Director **Usual Residence of Decedent** the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits ahow pernit. Pages 1 and 2 should be filed within 72 hours after death with the Maryle Department of Health and Mentel Hygiene. Important: If them 27 is marked other than "natural", or frems 23s or 28s-f show en injury or other traumatic event, the Healts! Examiner must be notified at once. MD Prince Georges 1 X Yes 2 □ No Director Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 144 Washington Road 20715 Taiwan, R.O.C. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: 11. Marital Status Wes Deceden! of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, atc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: Asian P 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 0 Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surneme) 8 Mooken Cheng Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Peter Yang/son 1454 Laburnum Street, McLean VA 22101 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Steta 1 Burial 2 Cremation 3 Removel from State Lakemont Memorial Gardens 1/6/00 4 Donation 5 Other (Specify) Davidsonville MD 21. Signature of Furieral Service Licenses Advent Funeral & Cremation Services Annapolis MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Death Physician Immediate Cause (Finel disease or condition resulting in death) /Medical 2 weeks Preumonia Communita Examiner Due to (or as a consequence of): Examiner physician and the burlei-transit The lew requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): P.O. Box 68760, Physician/Medical Due to (or as e consequence of): signed by the attending p d be deteched for use as or aignificant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown dementia Records, þ 24b. Were autopsy findings available prior to completion of cause of death? page 2 should Completed 24a. Was en autopsy performed? DUYOSCO certificate has 2 X No 1 Yes 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: funeral director, 25. Was case referred to medical examiner? 8 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1□ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 1 C Natural 2 Accident 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 5 Pending investigation To the Hospital or Attending within 24 hours effect death. To the Funeral Director: Afte completely filled in by the fun 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stele) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) D48101 00 Jones 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Donna Chambers 1833A Drive Maryland Anna poli 21401 32. Registrar's Signature 31. Date filed (Month, Day, Year)

DHMH 16 Rev 6/95

State

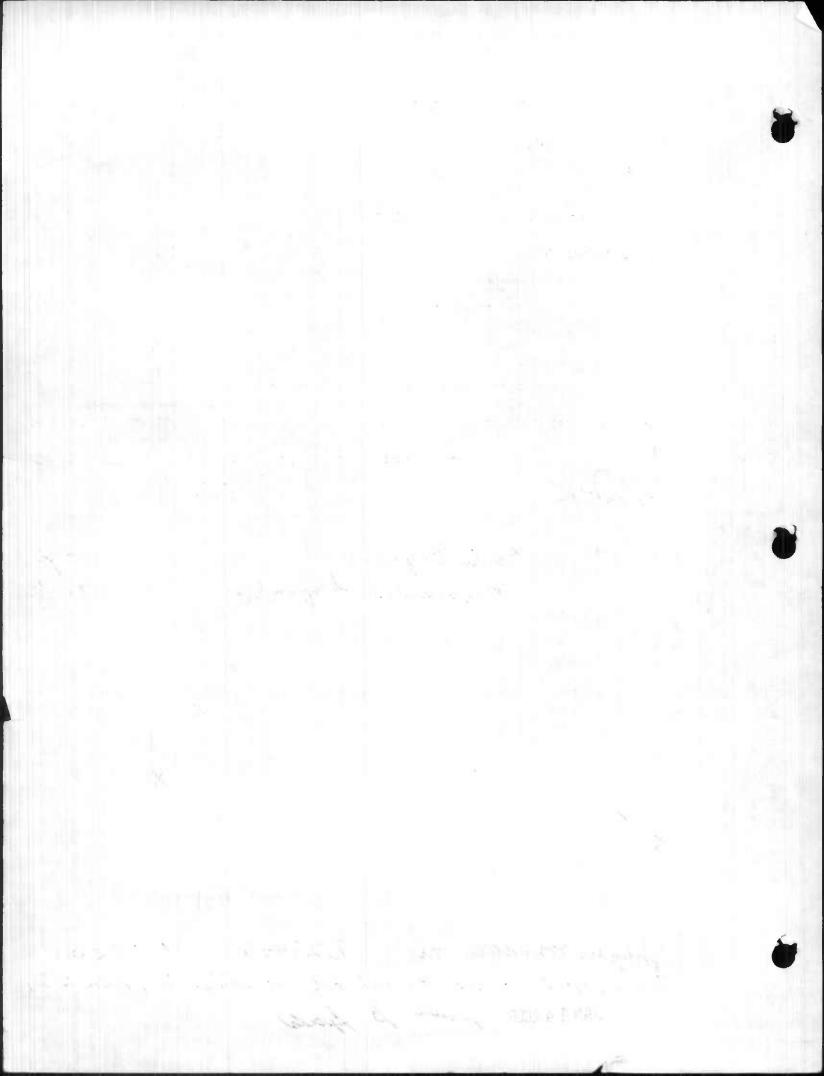
Registrar

JAN-05

2000

| | 1. Decedant's N | lama (First, Middla, | Last) | | 06/1 | ificate of | Douti | 2. Date of Death | | | 3. Tima of Death | |
|---|--|--|-------------------------------|--------------------------|--|--|---|-------------------------------------|-------------------|---|---|--|
| ysician Medical | | RC | BERT C. | ZENDG | RAFT | | | JAN. 11 | Day 200 | Year 0 | 10:30 PM | |
| aminer | 4a Facility Nam | e (If not institution, | give street end num | nber) | | | 4b. City, Town, or L | ocation of Death | 4c. County | of Death | | |
| | | JLLIVAN | | | | Williaday 4 Vana | WESTMI | | CARRO | | | |
| eral tor | 5. Social Security Number 6. Sex 212-14-8216 X M 2 F 7. As Usual Residence of Decedent | | | 7. Aga (In yrs. le 78 | Yrs. | If Undar 1 Yaar Months Days | Hours Min. | 8. Date of Birth 9/3/19 | 21 | Birthplaca (Steta or Foreign Country) MARYLAND | | |
| | 10a. State | 10b. County | | 10c. City, | Town or Loc | ation | | | | 10 | 0d. Inside City Limits | |
| tor | MD. | CARR | OLL | WES | STMINS | STER | | | | | 1 ☐ Yas 2 No | |
| Funeral Director | 10e. Street and | Number ULLIVAN | RD. | | | 10f. Zip Code 2 1 1 | 57 | 10 | USA. | Vhat Coun | try? | |
| | | Married 2 Marrie | Armed For | 2 No | | as Decadent of H Yes, specify Cub | Hispanic Origin? (Span, Maxican, Puerto Specify: | pecify Yas or No- o Rican, atc.) | | e - Americ k, White, | etc. | |
| d by | 3& Widowe | 3 Wildowed 4 □ Divorced Year or Dates: WT | | | | ent's Usual Occup | action | | 6b. Kind of Bu | | WHITE | |
| Completed | | Specify only highast secondary (0-12) | greda completed) College (1- | -4or 5+) | (Giva k life. D | ind of work done O NOT use retire ANAGER | during most of wor | king | EDUCA | | ustry | |
| Be Co | | | | | | | | | | e) | | |
| ToB | | ALBERT GLOYD ZENDGRAFT MARY ETHEL BUCKINGH | | | | | | | | | | |
| | | s Name/Relationship | | | | | end Number or Ru | | | | | |
| To | | EY F. HA | RRIS -S | | | | AVE.,H | | | | | |
| | 1 Burial 2 Cramation 3 Ramovet from Stata cometery, cremetory or other place) | | | | | | | | | | | |
| 1000 | 4 Donation 5 Other (Specify) WESTMINSTER CEMETERY 1 / 15 / 2000 WESTMINSTER 22. Nama and Address of Facility FLETCHER FUNE 254 E. MAIN ST., WESTMINSTER | | | | | | | | | | OME | |
| | 23a, Part1, Ent | er tha disaase, of o | omplications that ca | ausad the death. | | | | | | 110. | Approximate | |
| an ar | Immediate Cau | heert failure. List or se (Final | | | | 75 | | | | | Interval Between Onset end Death | |
| ner | disease or condition resulting in death) a. Challet Stage Co PD | | | | | | | | | I | Top | |
| iner | | | , n | ruse | ardi | e de | rfacet | im | | | 1 webs | |
| Examiner | Sequentially lis if any, leading to cause. Enter U Ceuse (Disease | t conditions, to immediate | 0. | | as a consequ | | V | | | | | |
| hysician/Medical Examir | Ceuse (Disease that initiated ev rasulting In daa | ents | С. | Due to (or | as a consequ | enca of): | | | | | | |
| Physician/M | Port II Other al | gnificant condition | d | ath but not rocul | tine in the un | doduing anuse ai | uan in Part I | 23b Did to | bacco use coo | ntribute to | the cause of death? | |
| | Part II. Other el | gnineant conditions | s contributing to de | ath but not resul | iting in the un | denying cause gr | ven in Per I. | 1AY | | | bably 4 Unknow | |
| Completed by | | | | | | | | 24e. Was er perform | n eutopsy ned? | av | ere autopsy findings allable prior to mpletion of cause death? | |
| mo: | 1.4 | | | | | | | 1 ☐ Ya | s 200 No | 10 | Yes 2□ No | |
| Be | 25. Was case reexaminer? | eferred to medical | | | | | 28. Plece of Dea | ath (Check only one | 9) | | | |
| 0 | 1 Yes | No No | | | R/Outpatient | 3LI DOA | | lome 5 Reside | | | y) | |
| Certification: | 27. Manner of D 1 Naturel 2 Accide 3 Suicide 4 Homici | 5 Pending Investiga 6 Could no | tion t be 28e. Plece | of Injury - At hon | 28b. Time of Injury na, farm, stre | | ry at rk?]Yes 2□No | | | | | |
| | | | | ng, etc. (Specify) | | | | City or Town | | | | |
| edicai | 29a. Certifier (Check only one) | | | sis of exemination | | | me, date and placa opinion, death occu | | | | | |
| × | 29b. Signature | and title of cartifier | | | | 29c. Licen | sa number | 25 | d. Date signe | d (Month, | Day, Year) | |
| complately filled in by the fune Medical Certification | 1 has 41 mobileton Mrs D25443 1-14 | | | | | | | | | 42 | 500 | |
| | John W. milletin Ms D25443 1-142 | | | | | | | | | | | |
| 0 | 30. Name and 8 | ddress of person w | Lelita | e of deeth (Item | 23a) (Type, F | Print) Poole R. | (Wi | itmins | In. | m | L21157 | |

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1 Decedent's Name (First Middle Last) **Physician** 14, 2000 Amann January 4:10 a.m. BABY GIRL /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Memorial Hospital Frederick Frederick 9. Birthplaca (State or Foreign Country) Mary Land If Under 1 Year If Under 24 Hrs. 5. Social Securify Number 7. Age (In yrs. lest birthdey) 8. Date of Birth (Month, Dey, Year) Jan. 14, 2000 6. Sax **Funeral** 1 M 2 TF Months Days Hours NONE Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Hems 23s or 25s-f shoy 1 Yes 2 No Director Frederick should be flied within 72 hours after death with the M not Mental Hygone.
I marked offber than "naturel", or feme 23a or 28e-7 a marked offber than "naturel", or feme 23a or 28e-7 umatic event, the Medical Examiner must be notifie New Market 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10599 High Beach Court 21774 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian. Bleck, White, etc. 1 ☑ Never Married 2 ☐ Married white 1 Yes 2 No Specify: Baltimore, Maryland 21215-0020 py 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Uaual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4or 5+) infant infant infant infant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Lest) unknown Shelley Nadine Amann 19a. Informant'a Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an ā Department of Health a important: if them 27 is any injury or other tracestics. Shelley Nadine Amann/mother 10599 High Beach Court Ne Market, MD 21774 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cremation 3 ☐ Ramoval from State 4 ☑ Donation 5 ☐ Other (Specify) 21. Signature of Fune el Service Licens Wade 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Mirector Mac wille Baltimore, MD 21201 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that ceuaed the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. **Physician** Immediate Cause (Finat /Medical 27 waxs disease or condition resulting in death) Examiner Due to (or as a consequence of): Physician/Medical Examiner nding physician and use as the bunal-transit The law requires that the death certificate be executed Sequentially list conditiona, if any, leading to immediate ceuse. Enter Underlying Ceuse (Diseasa or injury that initiated events Due to (or as a consequence of): Box 68760. ed by the attending physician detached for use as the burin that initiated events resulting in death) Last Dua to (or as a consequence of): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part t. 23b. Did tobacco use contribute to the cause of death? 1 Yaa 2 No 3 Probably 4 Unknown Division of Vital Records. by 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Was an autopsy performed? Be Completed certificate has 1 Yes 2 No 1 ☐ Yes 2 ☐ No i or Attending Physician: after death. 25. Was case reterred to medical 26. Piece of Deeth (Check only one) Hospitat: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 21 No Certification: To this 28c. Injury at Work? 27. Menner of Death 28d. Describe how injury occurred 28b. Time of After 1 Natural 5 Pending Investigation 1 Yes 2 No 2 Accident rilled in by the 28f. Location (Streat and Number or Rurel Routa Number, City or Town, State) 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicat Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medicai 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 1058 FLEDERICK 30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)

Registrar

Smith

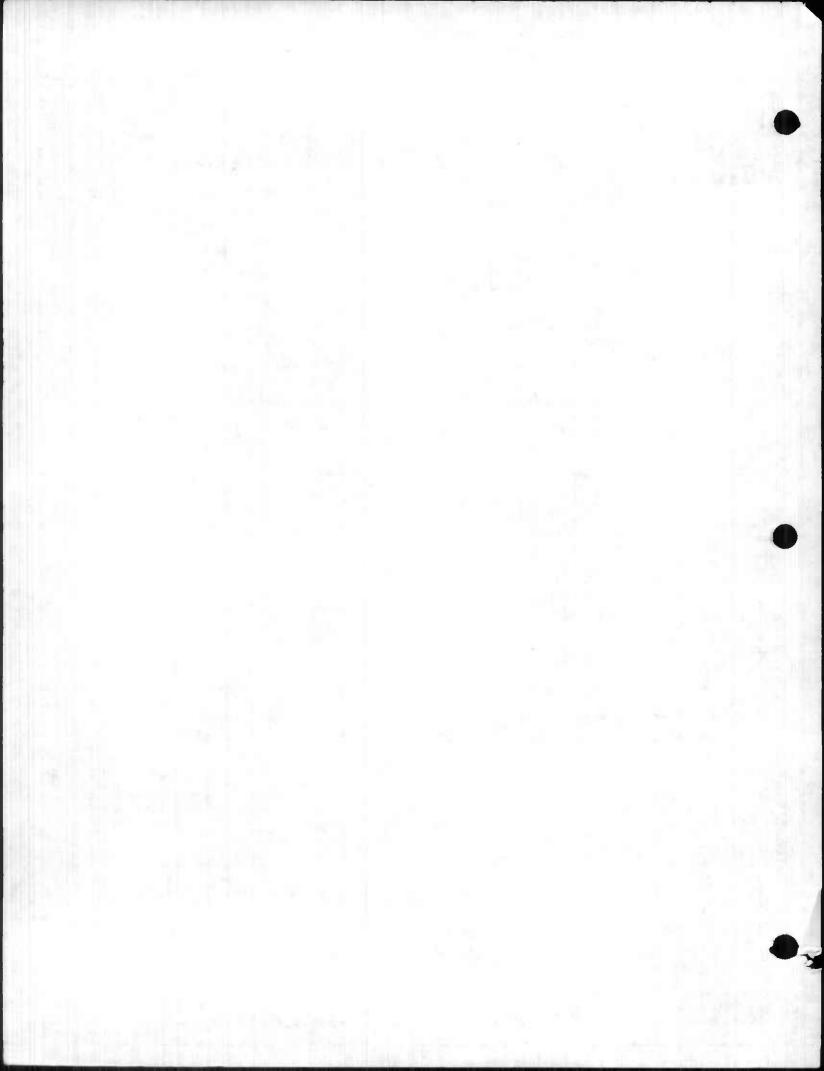
31. Date filed (Month, Day, Year)

DHMH 16 Rev 6/95

MEDICAL

NICE ATER

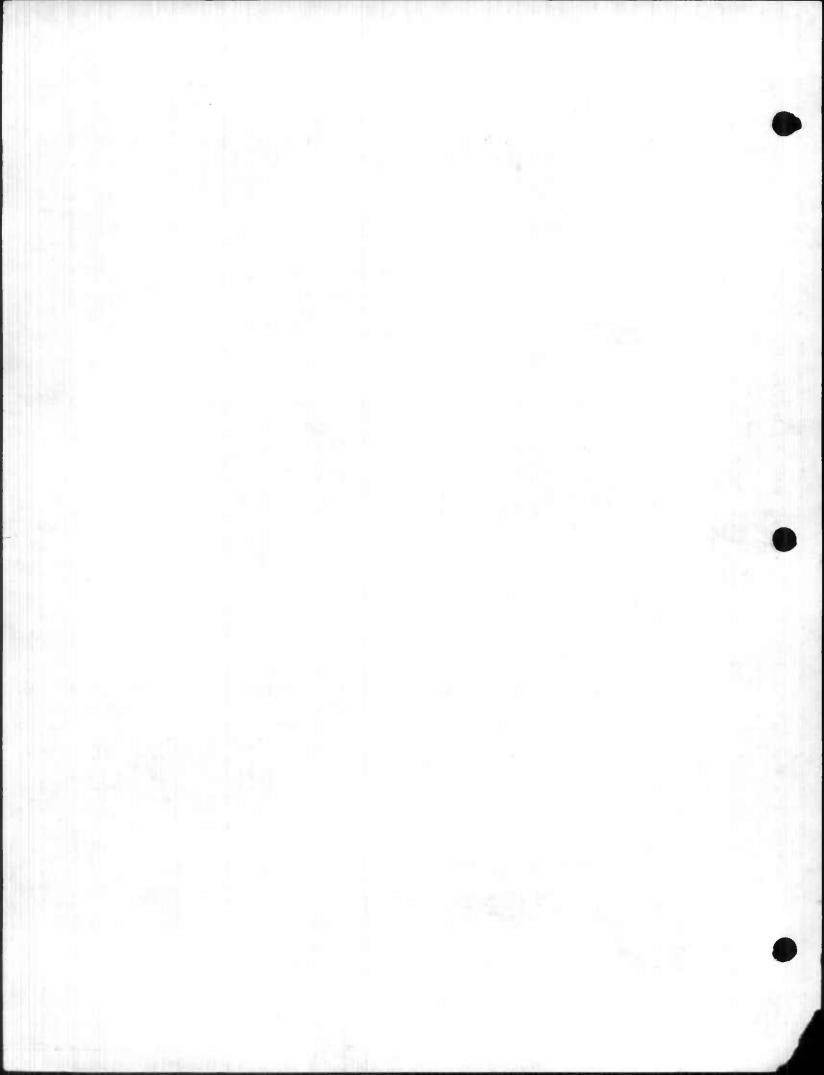
32. Registrar's Signature



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 2 4 4 4

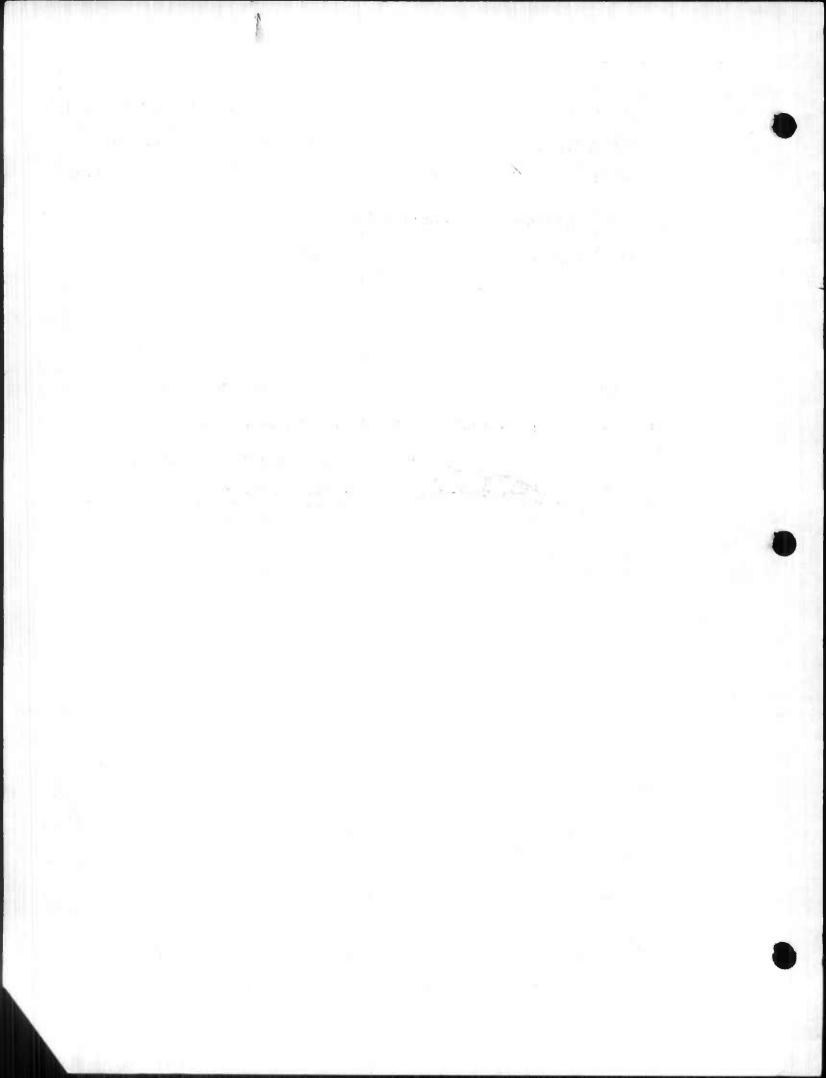
| | | | | | | | | | | | Reg. No. | | | |
|--|--|--|---|--|--|--|--|--|------------|--|--|--|---|---|
| | 1. D | ecedent's Name (First, Middle, L. | ast) | | | 1,196 | | | | 2. Data of D Month | eath Day | , | Year | 3. Tima of De |
| cian Iical | | ARTHUR ANDERSON | N | | | | | | | JANUA. | | | - 41 | 5:22AM |
| iner | 4a F | acility Nama (If not institution, gi | ve street and nu | mber) | | | 1 | b. City, To | wn, or L | ocation of Dea | - | County of | | |
| | GREATER BALTIMORE MEDICAL CENTER TOWSON | | | | | | ON | BALTIMORE | | | E | | | |
| | | | Sex | 7. Age (In yrs | | If Under | | If Under | 24 Hrs. | 8. Data of B | irth | | | lace (State or Fe |
| | 23 | 30-16-1916 al Residence of Decedant | 1⊠M 2□ F | 76 | Yrs. | Months | Days | Hours | Min. | Jufferth 1 | by, Yerny 2 | 23 | COURT | Khown |
| | - | Stata 10b. County | | 10c. C | ity, Town or Lo | ocation | | | | | 10d. Inside City | | | Od. Inside City L |
| Ö | | MD N/A | | | Baltin | more | | | | | | | | 1 X Yas 2 |
| 9 | 100 | Street and Number | | | | 10f. Zip | Code | | | | 10g. Citize | en of Wh | net Count | trv? |
| Funeral Director | | | | | | | | | | | log. on. | | | ,. |
| eral | 11 W. Clements St 12. Wes Decedent Ever in U.S. Armed Forcas? 13. Was Decedent of Hispanic Origin If Yas, specify Cuban, Mexican, P | | | | | | inin 2 (Co | acit. Van as A | 10 1 | USA | | an Indian, | | |
| | | | Armed F | orcas? | J,S. 13. | If Yas, spec | city Cubi | an, Mexica | n, Puerto | Rican, etc.) | | | White, | |
| - | | Never Merried 2 Married Widowed 4 Divorced | 1 ☐ Yas If Yas, Gi Year or D | va ** | | 1 Yes | 2 No | Specify: | | | | Specify: | whi | te |
| Completed | | 15. Decadent's E (Specify only highest gr | ducation rade completed) | | 16a. Dece (Give | dent's Usua kind of wo DO NOT us | al Occup | ation during mos | at of work | ing | 16b. Kin | d of Busi | iness/Ind | lustry |
| 1 | E | emantary/Secondary (0-12) | | 1-4or 5+) | lite. | DO NOT us | se retired | 1) | | | | | | |
| 5 | ur | RANOWN Fathar's Nama (First, Middle, Las | unknow | 1 | u | nknow | 'n | | | | | | ınkno | own |
| Be | 17. F | Fathar's Nama (First, Middle, Las | 1) | | | | | 18. Moth | er's Nam | e (First, Midd | le, Maiden S | Sumame) |) | |
| 9 | unknown | | | | | | | uı | nknown | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or F | | | | | | | | | ral Route Num | ber, City or | Town, S | tate, Zip | Code) |
| | | GBMC 6701 N. Ch | arles S | t Balt | imore, | MD | 2120 |)4 | | | | | | |
| | | Mathod of Disposition | | | Ptace of Dispo | osition (Nan | me of | na! | | Data | 20c. Loc | ation - C | ity or To | wn, Stata |
| | | 1 ☐ Burial 2 ☐ Cramation 3 [4 ☐ Donation 5 🖾 Other (Special | | Stata | 000.0.9, 0.0. | | , pia | , | 1 | | 1 | | | |
| | | | ** | 0 | 2: | 2.Name.an | nd.Addre | es of Facili | tv | 1 6EE 1 | T Dol | +-1 | - 100 | Ctroot |
| | State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 | | | | | | | | | | | | | |
| | 1 | 4anjuns | 1/11 | wee | | | | | | | | | | |
| | 238 | 23a. Part t. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shick, or haert failure. List only one cause on each line. Approximate Interval Between Onset and Deatt | | | | | | | | | | | | |
| | Immediate Course /Final | | | | | | | | | | | Oriset and Dea | | |
| | Immediata Causa (Final diseasa or condition RUSPIRATUILY FAILULE | | | | | | | | | | | | 1 | |
| | dise | asa or condition | . 13 | ESPIR | וטדטו | 24 | F | 716 | 1(2 | 6 | | | t | |
| | dise | nediata Causa (Final lessa or condition ulting in death) | a. 12 | | Or as a conse | | | 716 | 1(2 | 6 | 1 | | 1 9 | 110 |
| | dise | asa or condition | | Dua to (| or as a conse | quence of): | | | | | | | † † † † † † † † † † † † † † † † † † † | |
| | dise | lesse or condition ulting in death) | | Dua to | or as a conse | quence of): | 0 | | | | | | 1 | |
| LAGIIIII | dise | lesse or condition ulting in death) | | Due to (| (or as a conse | quence of): | 0 | 200 | S | COSI | > | | † † † † † † † † † † † † † † † † † † † | |
| ical Examiner | Seq if an caus that | uesa or condition ulting In death) uentially list conditions, ny, taeding to immadiate sa. Entar Underlying se (Disease or injury initiated events | | Dua to (Dua to (| (or as a conse | quence of): | 0 | 200 | S | COSI | 3 | | t : : : : : : : : : : : : : : : : : : : | |
| Medical Examiner | Seq if an caus that | lesse or condition ulting in death) | | Dua to (Dua to (| or as a consecutive or as a consecutive of the cons | quence of): | 0 | 200 | S | COSI | 3 | | t : 9 | |
| ician/Medical Examiner | Seq if an caus Caus that | uentially list conditions, y, taading to immadiate sa. Entar Underlying so (Disease or injury initiated events liting in death) Last | c | Dua to (| (or as a consection as a conse | quence of): | - A | -NO | S 12 C | C 10 S (· | | ass confi | t t t t t t t t t t t t t t t t t t t | o the cause of d |
| II SICIALI MEDICAL EXAMINES | Seq if an caus Caus that | uesa or condition ulting In death) uentially list conditions, ny, taeding to immadiate sa. Entar Underlying se (Disease or injury initiated events | c | Dua to (| (or as a consection as a conse | quence of): | - A | -NO | S 12 C | 230. 04 | d tobacco u | | | the cause of d |
| y Physician/Medical Examiner | Seq if an caus Caus that | uentially list conditions, y, taading to immadiate sa. Entar Underlying so (Disease or injury initiated events liting in death) Last | c | Dua to (| (or as a consection as a conse | quence of): | - A | -NO | S 12 C | 230. 04 | | | | • |
| TO DE LINE INTERIOR ENGINEER | Seq if an caus Caus that | uentially list conditions, y, taading to immadiate sa. Entar Underlying so (Disease or injury initiated events liting in death) Last | c | Dua to (| (or as a consection as a conse | quence of): | - A | -NO | S 12 C | 23b. Di | d tobacco u Yes 20 | □No : | 3 Prot | pebly 472Un |
| icion by anysicial michical Examinica | Seq if an caus Caus that | uentially list conditions, y, taading to immadiate sa. Entar Underlying so (Disease or injury initiated events liting in death) Last | c | Dua to (| (or as a consection as a conse | quence of): | - A | -NO | S 12 C | 23b. Di | d tobacco u | □No : | 24b. We | pebly 4 Lin ere autopsy find allable prior to impletion of cause |
| merca at a management and a paradem | Seq if an caus Caus that | uentially list conditions, y, taading to immadiate sa. Entar Underlying so (Disease or injury initiated events liting in death) Last | c | Dua to (| (or as a consection as a conse | quence of): | - A | -NO | S 12 C | 23b. Di | d tobacco u Yes 20 is an autops formed? | No : | 24b. We | pebly 4 Din ere autopsy find aliable prior to mpletion of caus death? |
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| and the same of th | Sequilitarios Part | was casa referred to medical examinar? II. Other algnificant conditions Was casa referred to medical examinar? II. Yes 25 No Manaar of Death Denatural 5 Panding invastigation | d | Dua to (| for as a consection as a conse | quence of): YU (r) quence of): quence of): underlying c | cause give | ren in Part 26. Place Ner: 4 N | S (12 C- | 23b. Di 1[24a. We per th (Check only | d tobacco u Yes 20 is an autopr formed? Yes 20 y one) sidence 6 | No : | 24b. We ave cor of c | ore autopsy find aliable prior to mpletion of causdesth? |
| to be completed by any sicially | Sequil arcauthat resu | was casa rafarred to medical axaminar? III. Other algnificant conditions Was casa rafarred to medical axaminar? III. Other algnificant conditiona Was casa rafarred to medical axaminar? III. Other algnificant conditional axaminar? | d | Dua to (Dua to | or as a consection of a consection of as a consection of a consection | quence of): YU (r) quence of): quence of): underlying c | DA Oth | 26. Place Place 4 N y at k? | S (12 C- | 23b. Di 1[24a. We per th (Check only ome 5 Re 28d. Describ | d tobacco u Yes 20 is an autops formed? Yes 24 one) sidence 6 e how injury | No S | 24b. We ave cor of a 1 [| ore autopsy find aliable prior to mpletion of causdesth? |
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| edical certification. To be completed by any alliant | Sequili arcauthat resultat res | was casa rafarred to medical saxminar? III. Other algnificant conditions Was casa rafarred to medical saxminar? III. Other algnificant conditiona Was casa rafarred to medical saxminar? III. Other algnificant conditiona Certifier (Check only one) Signatura and titla of certifiar | Hospital: 28a. Data (Moron be build bysician: To the mitner: On the band mar | Dua to (Dua to | or as a consection of as a consection of as a consection or as a consection or as a consection or as a consection or as a consection of as a consection or as a conse | quence of): YU (Care of the control of the courted t | DA Other Deause give the property of the prope | 26. Place Pen in Part 26. Place Pen in Part 27. Place Pen in Part 28. Place Pen in Part 29. Place Pen in Part | S (12 C: | 23b. Did 1[24a. We per th (Check only one 5 Re 28d. Describ 28f. Location City or 7 | d tobacco u Yes 2 Is an autoport formed? Yes 2 Yone) sidence 6 a how injury (Street and own, State) e cause(s) a, date and 29d. Date | No Sy Dio | 24b. We ave cor of a cor or sura | pebly full or autopsy find aliable prior to mpletion of caudeath? Yes 2 No |
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DHMH 16 Rav 6/95



| | | | #6 PER F.H. G780 2-1-20 | | C | ertificate | e or | Death | 2. Date of De | Reg. No. | 2 7 | me of Deeth | |
|------------|--|----------------|---|--|--|----------------------------------|-------------------------|---|---|------------------------------------|--|--|--|
| П | Physic | | Myrtle Irene | | | Month () 1 | Day | Year | : 15 PM | | | | |
| | /Medi Exami | | 4e. Facility Neme (If not Institution, give | | 4b. City, Town, or Lo | 0 1 | | | . 1 J F M | | | | |
| | LAGIIII | 1101 | Maruland Masoni | c Homes | | | | Cockeys | ville | Balt | imore | | |
| | Funeral | | 5. Social Security Number 6. Se | 7. Age (| In yrs. lest birthde | y) If Under Months | | If Under 24 Hrs. Hours Min. | 8. Dete of Bir (Month, De 1 2 0 9 | | | | |
| | Director | | 214-20-5594 | □M 2/K F 95 | 96 Yrs. | | 20,0 | 7100.0 | 12 09 | 1904 | Maryla | nd | |
| | and w | | Usuel Residence of Decedent 10e. Stete 10b. County | 1 | 0c. City, Town or | Location | | | | | 10d. ins | ide City Limits | |
| | Mary | to | MD Baltimore Cockeysville | | | | | | | | | Yes 2 XNo | |
| | h the | Director | 10e. Street and Number | | | 10f. Zlp | Code | | | 10g. Citizen of \ | What Country? | | |
| | th wil | | 300 International | Circle | | | | 21030 | | US | Α | | |
| 21215-0020 | d 2 should be filed within 72 hours after death with the Maryland thend Mental Hygiene. 7 ie marked other than "natural", or itema 23a or 28a-f show traumatic event, the Modical Examinat must be not east. | by Funeral | 11. Maritel Stetus 1 Never Merried 2 Married 3 Widowed 4 Divorced | 12. Wes Decedent Eve Armed Forces? 1 Yes 22 No If Yes, Give Yeer or Detes: | 1 ☐ Yes 2♥ No If Yes, Give 1 ☐ Yes 2♥ No | | | | ecify Yes or No Rican, etc.) | | e - American Ind ck, White, etc. :: White | an, | |
| 2-0 | netur | Completed | 15. Decedent's Edu (Specify only highest grad | ucation de completed) | 16a. Decedent's Usuel Occupetion (Give kind of work done during mo | | | | | 16b. Kind of B | usiness/Industry | | |
| 2 | within ene. then | dm | Elementary/Secondery (0-12) | College (1-4or 5+) | | | | | | Own | Home | | |
| 9 | Hygid Hygid ent, n | Be Co | 17. Fether's Neme (First, Middle, Last) | 110111 | emarci | | 18. Mother's Nemo | e (First, Middle | | | | | |
| ıları | Mental I arked of arked of artic eve | To B | Harry Clay Hall | | | Mary El | izabeth | Myers | | | | | |
| Maryland | 2 should end Men le marke aumatic | | 19e. Informant's Neme/Reletionship (T | ype, Print) | al Route Numb | er, City or Town, | Stete, Zip Code) | | | | | | |
| | lealth m 27 | | George H. Antho | | | | | Dr., Bal | | | | | |
| 20 | Peges 1 nert of H int: If ite | | 20a. Method of Disposition 1 KBurlel 2 Cremetion 3 If | Removel from Stete | | remetory or of | her plac | | Dete | | City or Town, St | ete | |
| Baltimore, | pemit. Peges 1 and Department of Health Important: If Item 27 any Injury or other to once. | | 4 ☐ Donetion 5 ☐ Other (Specify, 21. Signeture of Funerel Service Licens | 2 | Oak La | wn Ce 22. Name end | | | 00 | Baltimo | ore, MD | | |
| Ba | permit. F Departme Importan any Injur | | | MUNICIA | | Lommo | n E | uneral H. | ome | | | | |
| | _ | | Michael J. Flat 23a. Pert1. Enter the diseese, or comp shock, or heert failure. List only o | Timor or respiratory e | rium, MI | D_21093 Appro | ximate al Between | | | | | | |
| | Physician /Medical Examiner | | Immediate Cause (Finel disease or condition resulting in deeth) | Carebro! | Jasula | - Disa | case | | | | Onse | snd Death | |
| | be fist | Examiner | | b. 4Thers | chester | Vasa | ule | n Diseas | e | | | | |
| | and n and el-trar | Exar | Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | Du | e to (or es e cons | equence of): | | | | | | | |
| 68760, | cate be executed physicien and s the buriel-transit | edical | | | | | | | | | | | |
| _ | ng ph | _ | resulting in deeth) Lest | | (| | | | | | i | | |
| ROX | eath certific attending p | lan | | d | | | | | | | | | |
| 0 | the a | Physician/M | | ntributing to death but not resulting In the underlying cause given in Pert I. | | | | | 23b. Did | tobacco use co | ntribute to the c | | |
| 1 | that the part of t | by Ph | Somer Demertini, | Conjest in | i Hear | * Fa | ele | ne | 10 | Yes 2 No | 3 Probably | 48 Unknow | |
| ecords, | law requires that the death certificate be executed es been signed by the attending physicien and a should be detached for use as the bunel-transit | Completed b | , | | | | | | | an autopsy ormed? | 24b. Were aut available completic of deeth? | opsy findings prior to in of cause | |
| T T | The law | Соп | | | | | | | 10 | Yes 2000 | 1 ☐ Yes | 2€ No | |
| Vital | Attending Physician: The or death. ector: After this certificate by the funeral director, pag | Be o | 25. Wes case referred to medical examiner? | Hospitel: | | | Oth | 28. Place of Deatl | | | | | |
| ō | Phys rthis | T. To | 1 ☐ Yes 2 ☐No 27. Menner of Deeth | 28e. Dete of Injury | 2 ER/Outpati | | A | 4 Mursing Ho | | dence 8 Oth | | | |
| 0 | oding F Ith. : After e funer | ation | 12 Neturel 5 ☐ Pending 2 ☐ Accident Investigation | (Month, Dey Y | ear) Injury | М | 3c. Injur Wor 1 🗆 | k? Yes 2□No | | | | | |
| DIVISION | To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Af completely filled in by the fu | Certification: | 3 Sulcide 8 Could not be 4 Homicide determined | 28e. Plece of fnjury building, etc. (| - At home, farm, s Specify) | street, fectory, | office | | | | | | |
| | Hosp 24 hou Fune Itely fi | edicai | 29e. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami | sician: To the best of more: On the basis of ex | aminetion end/or | eth occurred e Investigetion, | t the tin | ne, dete end plece, pinion, deeth occurr | end due to the ed at the time, | ceuse(s) end ma dete end place, | anner as stated. and due to the ca | iuse(s) | |
| | o the | Mec | 29b. Signeture end title of certifier | end manner stated | | 29c. | Licens | e number | | 29d. Dete signe | d (Month, Dey, Y | ear) | |
| | ("]" | | P Po L. | 40 | | 4- | Di | C. L. | | 2/1 | 00 | 1 | |
| | My | | 30. Name and address of person who co | ompleted cause of deat | h (Item 23a) (Type | e, Print) | 131 | 704 | | 1.1 | -0 | | |
| | VV | | LOBERT LIBERTO, | | | st. | BA. | Lty, m | ul 21 | 774 | | | |
| | Sta | ite | 31. Date filed (Month, Dey, Year) | 32. Registrar's | Signature | D | 0,00 | uks | | , | | - | |

DHMH 16 Rav 6/95



Piease Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Juanita Lee Armstrong January 28 2000 5:00 am 4e Facility Neme (If not Institution, giva street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Yaar | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Hours Months 1□M 2□F Yrs. 220-30-5023 66 July 30,1933 Kentucky Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Anne Arundel 1 Yes ZENO Odenton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 554 Rita Drive 21113 USA Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indien, 11 Maritai Status 12. Was Decedent Ever in U,S. Armed Forcas? Black, White, etc. 1 ☐ Yas 2 ☑ No If Yes, Give Year or Detas: 1 Navar Married 2 Married 1 Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) Homemaker Own Home 17. Fathar's Name (First, Middle, Last) 18. Mother's Name (First Middle, Maiden Sumame) Charles Hunt Irma K. Anderson 19e. Informant's Neme/Reletionship (Type, Print) (Husband) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dexter J. Armstrong, Jr. 554 Rita Drive, Odenton, MD 21113 20b. Plece of Disposition (Neme of cematary, cremetory or other plece) 20e. Method of Disposition Dete 20c. Location - City or Town, State 02/02 ¥XBuriai 2 ☐ Cramation 3 ☐ Removel from State 5 Other (Specify) Maryland Veterans Cem. 4 Donetion Crownsville, MD 21. Signature of Funerel Service Licensee 22. Name end Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401 23a. Pert1. Enter the diseasa, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Finel NKNOWN diseese or condition resulting in deeth) Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Couse (Diseese or injury that initiated avents resulting in death) Lest Due to (or as a consequence of) Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown lure 24a. Was en autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? disease 1 ☐ Yes 2 ☐ No 25. Was case referred to medicat axaminer? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28e. Dete of Injury (Month, Dey Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Netural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide

and Box 68760. attending physician for use as the burie P.O. d be detach Division of Vital Records. peen : certificate this i or Attending F after death. Director: After After

Physician/Medical py Completed Be

Physician

/Medical

Examiner

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Funeral

Director

the Medical Examiner must be notifi-

"natural", or harra 23a or

Hygiene.

permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy, important: If them 27 is marked other any injury or other.

Physician /Medical

Examiner

the Manylar 28a-f show

altimore, Maryland 21215-0020

Medical To the F within 2 To the F V State Registrar

24 hours aft Funeral Di eletely filled in Hospital

pletely

Certification: To

29e. Certifian (Check only one)

31. Date filed (Month, Dey, Year,

FEB 0

29b. Signature and little of certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License numbe 29d. Date signed (Month, Day/ Year)

41816

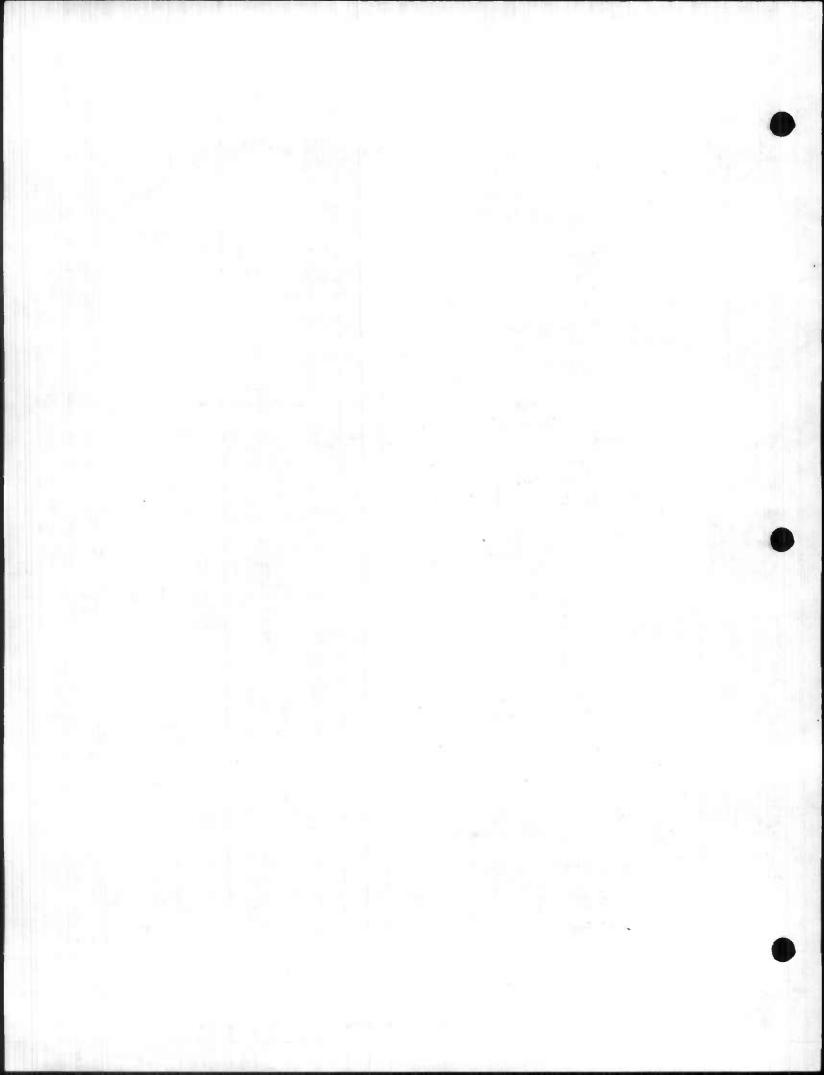
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21401

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AAMC 125 her

AS MID 32. Registrer's Signeture

DHMH 16 Rev 6/95



Please Type or Print in Biack Indelible ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] 02447 AMENDED ITEM #10g PER FH G780 2/12000 AH Certificate of Death 2. Dete of Death 3. Time of Death 1. Decedent's Nama (First, Middle, Last) **Physician** JANUARY 27, 2000 LEONID ARAKELOV 4:09 AM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nema (If not institution, give street and number) Examiner NORTHWEST HOSPITAL CENTER RANDALLSTOWN BALTIMORE If Under 1 Yeer | If Under 24 Hrs. | 8. Date of Birth Month, Day, Ye JUL. 29, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Year tX M 2□F 213-39-5368 Yrs 1946 RUSSIA Director 53 Usuat Rasidence of Decedant 10a. Stata 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show the Medical Examiner must be notified at MD BALTIMORE OWINGS MILLS 1 ☐ Yas 2% No Director 10g. Citizan of What Country? 10e. Street and Number 10f. Zip Coda 6 3-L SHASTA CIRCLE 21117 234 U.S.A. RUSSIA Funeral Rema 12. Was Dacedent Evar in U,S. Armed Forcas? Wes Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxicen, Puarto Rican, atc.) 14. Rece - American Indian 11 Marital Status Biack, Whita, atc. 1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Datas: 1 ☐ Nevar Married 2 X Merried 6 1 ☐ Yas 2 XNo Specify: WHITE Specify. þ 3 ☐ Widowed 4 ☐ Divorced "netural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT usa ratired) 16b. Kind of Business/Industry I Hyglene. Elemantary/Secondary (0-12) Collega (1-4or 5+) 12 MECHANIC AUTOMOTIVE 17. Father's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maidan Surnama) Be Pages 1 and 2 should be nent of Health and Mental ARAKELOV LEV MARY LABSKER and N 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) Department of Health as Important: If itsm 27 is any injury or other trac pncs. NATALYA ARAKELOV / WIFE 3-L SHASTA CIRCLE - OWINGS MILLS, MD 21117 20b. Ptace of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata 20a Mathod of Disposition Data 1 Buriat 2 ☐ Cramation 3 ☐ Removal from State 1/28/00 ARLINGTON CHIZUK AMUNO BALTIMORE, MD 4 □ Donation 5 □ Othar (Specify) 21. Signature of Funeral Service Lig 22. Name and Addrass of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or hear failure. List only one cause on each line. Approximata Intarvai Batwean Onsat and Death Physician Immediata Causa (Finat disaasa or condition resulting in death) /Medical MYOCARDIAL INFARCTION 2 HOURS Examiner Dua to (or as a consequence of) Physician/Medical Examiner Sequentially fist conditions, if eny, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last use as the buriel-trar Due to (or es a consequance of) Due to (or es a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? the 1 | Yes 2 | No 3 | Probably 4 N Unknown signed by þ 24b. Wara autopsy findings available prior to complation of ceusa of death? 24a. Was an autopsy parformed? Completed 1 ☐ Yas 2 🔀 No 1 Yas 2 No Be 25. Was cese raferred to medicel 26. Placa of Death (Check only ona)

The lew requires that the death certificate be executed Box 68760, P.O. Records, director, page 2 should certificate has of Vital Hospital or Attending Physician: this After Division after death. the

with the Manyland

death

filed within 72 hours after

Baltimore, Maryland 21215-0020

axaminar? 1 Yas 2 No

1 Natural

2 Accident

4 Homicida

3 ☐ Suicide

29a. Certifier

27. Mannar of Death 5 Panding invastigation

6 Could not be

Hospital: 1 ☐ Inpatient 2 🔀 ER/Outpatient 3 ☐ DOA 28b. Time of

Injury

28c. Injury at Work? 1 ☐ Yas 2 ☐ No 28a. Place of Injury - At home, ferm, street, fectory, office building, atc. (Specify)

Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 28d. Dascribe how injury occurred

28f. Location (Street and Number or Rural Routa Number, City or Town, State)

and mar esstated. 29b. Signature and tiple of certified

29c. Licansa number D51426

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicat Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Data signed (Month, Day, Year)

JANUARY 27, 2000

30. Nama and addrass of person who complated ceusa of daath (Item 23a) (Type, Print)

ELLIOT ROTHSCHILD

4000 OLD COURT ROAD

PIKESVILLE, MD 21208

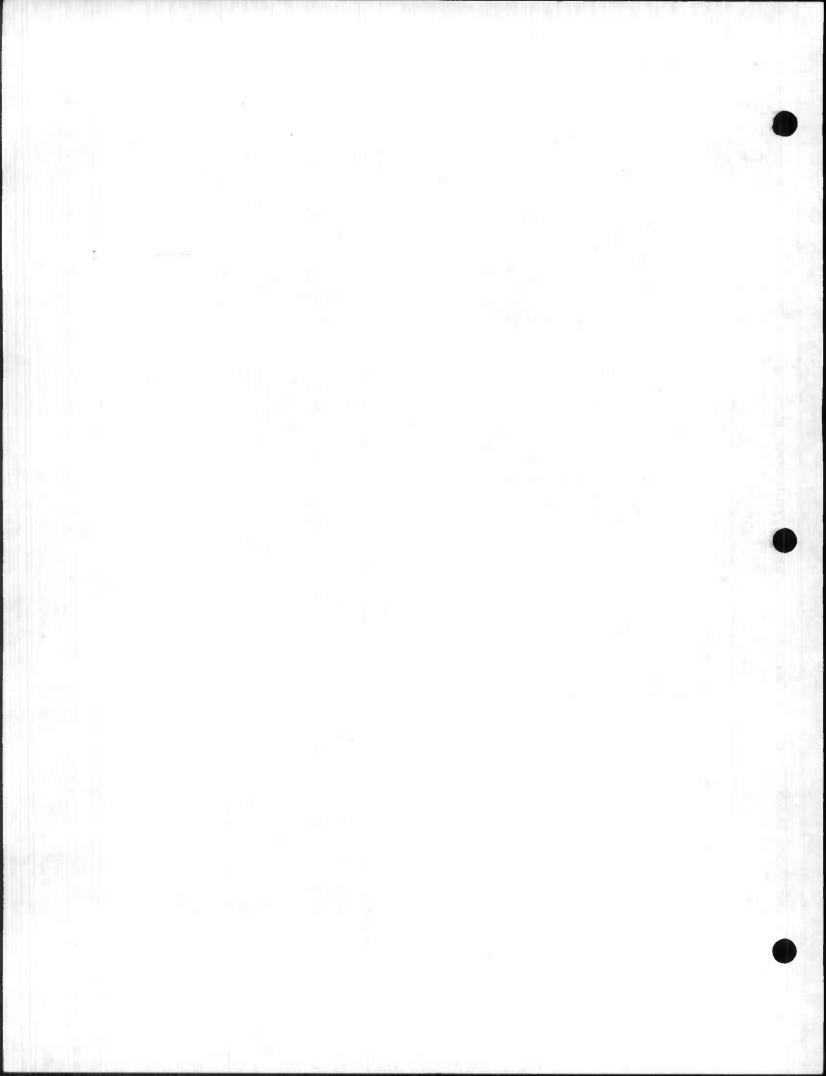
31. Data filed (Month, Day, Year) State Registrar

edical Certification: To

filled in by

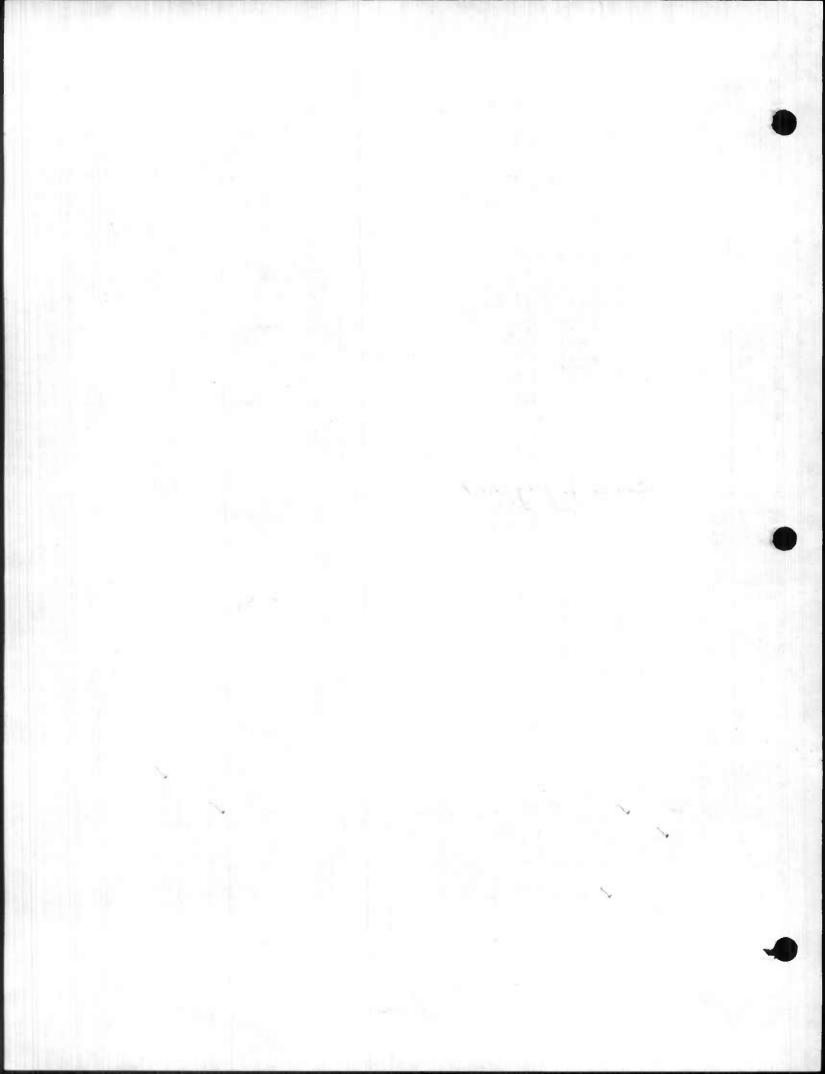
To the Hospital within 24 hours a To the Funeral D

32. Registrar's Signatura



State of Maryland / Department of Health and Mental Hygien 0 2 4 4 8

| | | | Ce | ertificate | of D | eath | | Reg. N | | U C. " | 7 -7 0 | |
|--|---|--|--|----------------------------------|--------------------------|-------------------------------|--|-----------------------------------|---|-------------------------------|---|--|
| Dh. aisian | 1. Decedent's Name (First, Middle, I | .ast) | | | | | 2. Date o | | Day Ye | aar 3 | Time of Death | |
| Physician /Medical | KU. | selyn Hattie | Bail | еу | | | Janu | | 31, 200 | | 8:04 A | |
| Examiner | 4a Facility Name (If not institution, g | | | | 4b | | or Location of D | eath 4 | lc. County of D | | | |
| | 2502 Lakeland | | | If Under 1 | 4 Vana | Balt If Under 24 | imore | | | N/A | | |
| Funeral Director | 220-76-2489 | 1 N N N E | s. last birthday 9 Yrs. | Months | Days | | | Day, Yea | 9.941 W | Birthplace Country) est | (State or Foreignia) | |
| B 1 | Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. fnside City I | | | | | | | | | | | |
| vith the Marylan t or 28a-1 show be notified at Director | Maryland N/ | A | | | Ltim | ore | | | | | 1⊠Yes 2□N | |
| | | Avenue | | 10f. Zip (| 21 | 230 | | | | USA | | |
| d with 72 hours after death video. To the Medical Examiner must completed by Funeral | 3 ☐ Widowed 4 ☐ Divorced | Armed Forces? If Yes, specify Cuban, Mexican, Puerto I | | | | | | | 14. Race - / Black, V Specify: \[| White, etc. | | |
| ed within 72 ho system. er then "natum f. the Medical Completed | 15. Decedent's (Specify only highest of | | (Giv | e kind of work | k done du | on ring most of | working | 16b. | Kind of Busine | ess/Indust | У | |
| Mary Mary | Elementery/Secondary (0-12) | College (1-4or 5+) | life. | DO NOT use | e retired) | | | | N/A | | | |
| | | er) | Neve | er Wor | | 8 Mother's | Name (First, Mid | Ma Mairk | | 7 | | |
| 4 2 should be the h and Mental Hy 7 is marked oth traumatic event | TTATIZ | | | | | | nita Ba | | | | F,J, H | |
| 5 5 8 5 | 19a. Informant's Neme/Relationship Juanita Burns | eet Bal | | | | | | | | | | |
| amit. Pages 1 a Appartment of Hea mportant: If them ny injury or othe IDSB. | 20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Spec | ☐Removal from State | Place of Disp cemetery, cre tro C | emetory or oth | her place) | | .2/1/00 | | Location - City | | | |
| Departition of the control of the co | 21. Signature of Furieral Service Lice Edward A. | ensee | 3 | 2. Name end | Address t1011 | of Facility Soc: | iety of | MD | , Inc. | MD | 21228 | |
| Physician | 23a. Part1. Enter the disease, or co shock, or heart failure. List on | mplications that caused the dea y one cause on each line. | ith. Do not er | nter the mode | of dying, | such as car | diac or respirato | ry arrest, | | Ap | proximete erval Between set and Death | |
| /Medical Examiner | Immediate Ceuse (Final disease or condition resulting in death) | 7 | | | YAGI | | | | | | | |
| | | | (or es a conse | , | 2 | 1 | 3 6 - A | _ | | 1 | YEAR | |
| n and lattransit | Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury | Due to (or as a consequence of): | | | | | | | | | | |
| nificate being physicial as the bur | Cause (Disease or injury that initiated events resulting in death) Lasf | c. HYPERTENSION 10 YEAR | | | | | | | | | | |
| attendii for use | | | | | | | | | | | | |
| at the death co | Part II. Other algniffcant conditions | contributing to death but not re | sulting in the | underlying ca | use given | in Pert I. | 23b. | Did tobac | o una contrit | buta to the | cause of deati | |
| EXD | | Α. | | | | | | Yas | 2 D-80 3 [| Probabl | y 4 Unkno | |
| The law requires that the take has been signed by the page 2 should be detached. | | | | | | | 24a. \ | Vas en au erformed | | availab | autopsy findings ble prior to etion of cause th? | |
| Page Page | | | | | | | 1 | ☐ Yes | 2 No | 1 □ Ye | s 2 No | |
| delan: The certificate rector, page Co | | Hospital: | | | Other | | Deeth (Check o | - | | | | |
| Physician: this certific ral director, | | 1 Inpatient 2L | ER/Outpatie | | ` | 4 LI NUISI | ng Home 5 MF | | | Specify) | | |
| De le le | 1 Natural 5 Pending 2 Accident investigati 3 Suicide 6 Could not | (Month, Dey Year) Injury Work? Injury Work? I □ Yes 2 □ No | | | | | | 28d. Describe how injury occurred | | | | |
| lal or Attendi s after death. In Director: A ed in by the f | 4 Homicide determine | d 266. Place of injury - At i | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Num City or Town, Stete) | | | | | | | or Hural Ho | ute Number, | |
| Hospi 4 hou Funer tely fill | | hyalcian: To the best of my kn eminer: On the basis of examin and manner stated. | owledge, dee etion and/or li | th occurred a nvestigation, i | t the time in my opir | , date and p nion, death o | lace, and due to occurred at the ti | the cause ne, date e | (s) and manne and place, and | er as stated due to the | i. cause(s) | |
| To the within 2 To the comple | 29b. Signature and title of certifier | per s | eth, | 9 . D | License r | 3 > L | +07 | 29d. [| Date signed (M | Aonth, Day | *** | |
| 8 | 30. Name and address of person who | completed cause of death (Ite | 23a) (Type | Print) | E AV | ENO | E BAI | TIL | TORE | MC | 5 212. | |
| State | 31. Date filed (Month, Dey, Year) | 32. Registrar's Sign | | Kar | 7 | | | | | | | |



State of Maryland / Department of Health and Mental Hygiene 12669 Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Jacqueline Donett Briggs 26, JAN 2000 3:00 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Stella Maris Hospice Towson Baltimore If Under 24 Hrs. If Under 1 Year 5. Social Security Number 8. Date of Birth (Month, Day, Year)
JULY 30, 1959 California 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 10 M 20 F 573-11-1019 40 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits must be notified at MD Laurel Howard 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Barrie 23a 9185D Hitching 20723 Post Lane USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. hours after 1 XYes 2 No If Yes, Give Year or Detes: 1 Never Married 2 Married altimore, Maryland 21215-0020 natural, or 1 Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filled within National Industries Elementary/Secondary (0-12) College (1-4or 5+) for the Blind Secretary 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) permit. Pages 1 and 2 should be fill.
Department of Health and Mental Hy
Important: If Ilsm 27 is marked oth
any injury or other traumatic event 89 Nansi Lee Butterfield Jefferson Davis Hyatt 2 19a. Informant's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carl R. Sticher/friend 9185D Hitching Post Ln., Laurel, MD 20723 20b. Place of Disposition (Name of 20a Method of Disposition Dete 20c. Location - City or Town, Stete cemetery, cremetory or other place) 1 ☐ Burial X☐ Cremetion 3 ☐ Removel Irom State
4 ☐ Donetion 5 ☐ Other (Specify) 1/27/00 Metro Crematory, Inc. Baltimore, 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Cremation Society of Maryland, Inc. George E. MacNabb 299 Frederick Rd. Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart leilure. List only one cause on each line. Approximete Intervet Between Onset and Deeth **Physician** Immediate Cause (Finel /Medical Saugmons Carcinoma. cell diseasa or condition resulting in deeth) Examiner Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieled events resulting in death) Last Due to (or as a consequence of): physician s the buriel P.O. Box 68760 Physician/Medical Due to (or es a consequence of): USB 88 Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 miknown 1 Yes 2 No ped ed l þ Records. Completed 24b. Were autopsy findings available prior to 24a. Was an autopsy completion of cause of death? page 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vitai or Attending Physician: 25. Wes case referred to medical axaminer? Be 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Residence 6 Mother (Specify) HOSPICE 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Menner of Death 1 Metural 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 24 hours after deat Puneral Director: 6 Could not be 3 Sulcide within 24 hours after de To the Funeral Directo completaly filled in by th 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, Jerm, street, Jectory, office building, etc. (Specify) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier edical (Check only one) \$ 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ムフニ D43725 January 27, 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 201-109 Bude River Neck Rd Baltimore MD 21221 MAHMOUD TATZICE

DHMH 16 Rav 6/95

State

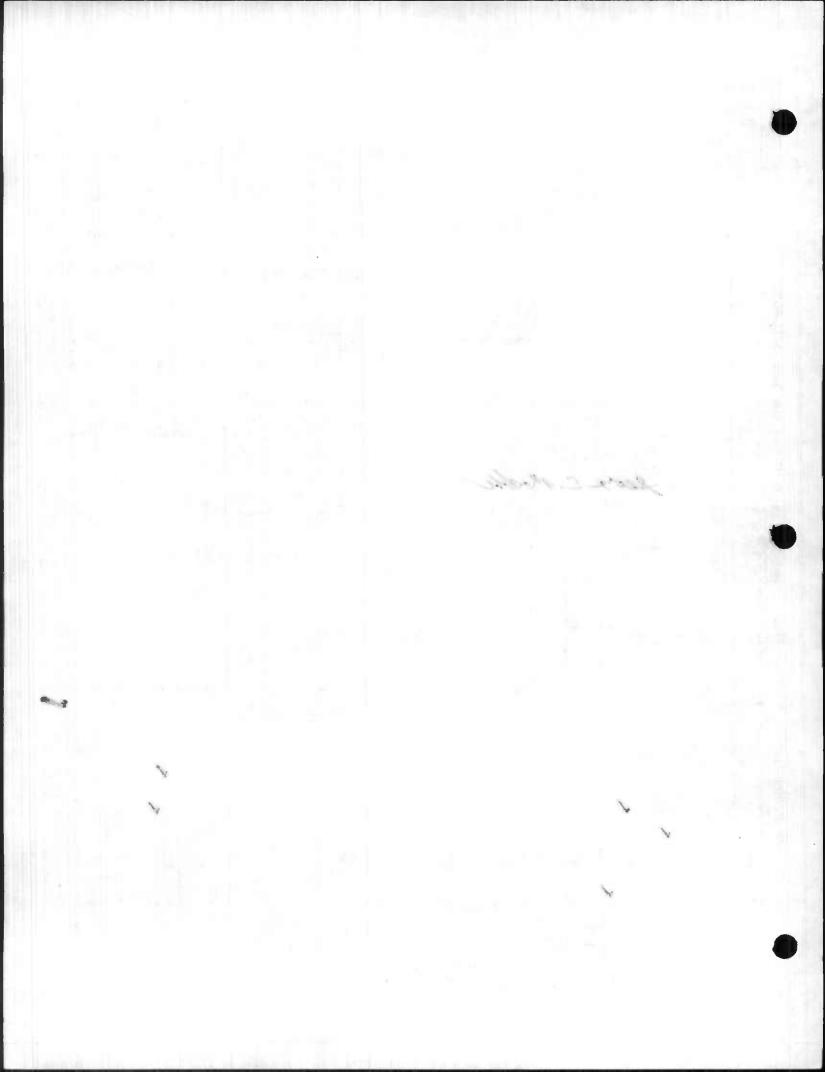
Registrar

31. Date filed (Month, Day, Year)

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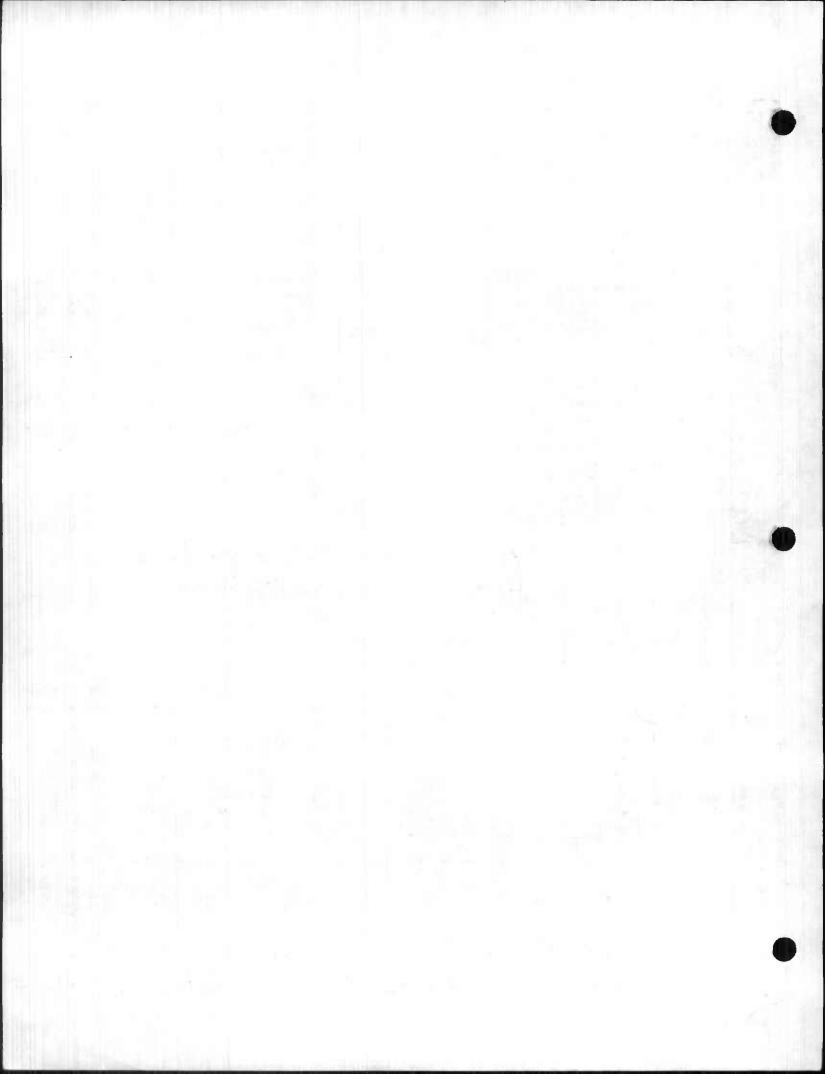
oaks

32. Registrar's Signature



| | | | | | Cert | ificate of | Death | - 1 - 1 1 | Reg. No. | U | 2400 | | | |
|--|-------------------|--|--|-------------------------------------|----------------------|------------------------------------|-----------------|---|--|---------------------------------|--|--|--|--|
| 0.1 | | 1. Decedent's Nama (First, Middle, L. | est) | | | | | 2. Data of Do Month | Death Day Year | | 3. Time of Death | | | |
| | sician edical | Rut | Ruth E. Brown | | | | | | 27, 2000 | | 11:15 AM | | | |
| | miner | 4a Facility Nama (If not institution, gi | | | | | | or Location of Deal | th 4c. County | of Death | | | | |
| | | 229 North Mo | | | | | Balti | | N/ | | | | | |
| Fune Direct | | | Sex 7. Ag | e (In yrs. last bir 79 | | If Under 1 Year Months Days | Hours N | Hrs. 8. Data of Bi Min. (Month, D. MAR 8, | 1920 | Coun | place (State or Foreign try) yland | | | |
| 9 Bx | | 10a. Stata 10b. County | | 10c. City, Tow | n or Loca | ition | | | | 1 | Od. Inside City Limits | | | |
| ith the Maryla or 28a-f show be notified at | Į, | MD N/A | | B | alt- | imore | | | | | 1 Yas 2 No | | | |
| r 28a | Director | 10e. Street and Number | | | art | 10f. Zip Code | | | 10g. Citizen of N | What Cour | ntry? | | | |
| 9 wit | | 229 North Mou | nt Stree | t | | 2122 | 23 | | US | A | | | | |
| 0020 ours after dea raff, or litera Examiner on | by Funeral | 11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced 12. Was Decedent Ever Armed Forces? 1 98 2 X No If Yes, Give Year or Dates: | | | | as Decedent of Yas, specify Cut | | (Specify Yas or No uarto Rican, atc.) | o- 14. Rad Blad Specify | ck, Whita, | can Indian, etc. 31 a c k | | | |
| 21215-0020 d within 72 hours at plane. r them "naturel", or the Medical Exam | Completed | 15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12) | 5+) | (Give kir | NOT use retire | during most of | working | 16b. Kind of B | | dustry e Duty | | | | |
| | | 17. Father's Nama (First, Middle, Las | 1) | 11 | urst | = | 18. Mothar's | Nama (First, Middle | | | z Duty | | | |
| land le file feet and | To Be | Sherman | Brown | | | | | Helen S | Johnson | | | | | |
| Mary d 2 shoul th and Mary 7 is mary traumats | - | 19a. Informant's Name/Relationship | (Type, Print) | 19b | . Mailing | Address (Stree | t and Number of | Rural Routa Numb | per, City or Town, | Stata, Zip | Code) 1 2 0 7 | | | |
| M sale | | Myrtle E. Bone | v/sister | | | | | | | | | | | |
| Ore of Hear | | 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 [| | 20b. Place of cemetal | Disposit y, crema | tion (Name of tory or other pla | ice) | Data | 20c. Location - | City or To | imore, MD | | | |
| t. Pages 1. Iment of Hs tant: If hen | | 4 □ Donation 5 □ Other (Speci | | Metro | Crem | natory, | Inc. 02 | /01/00 | Balti | more | , MD | | | |
| Balt Depart Import | 1000 | · () numa | 21. Signature of Facility Cremation Society of Maryland, Inc. 29. Part F. McDonald 22. Name and Address of Facility Cremation Society of Maryland, Inc. 299 Frederick Rd. Baltimore, MD 21228 | | | | | | | | | | | |
| | | 23a. Part1. Enter tha disease, or con shock, or heart failure. List only | ODSIC pplications that caused one cause on each li | I the death. Do r | | | | | | , 111 | Approximata Interval Between | | | |
| Physicia /Medic Examin | al | Immediata Causa (Final disease or condition resulting in death) | · Acc | te p | My | OCAVO | Dist | information | ction | | Onset and Death | | | |
| D == | ne i | | Athe | rosch | 0/6 | he CI | MIDVI | ASCY/Ar | disea | se | | | | |
| 68760, tificate be executed up physician and as the buriel-fransit | Examiner | Sequentially list conditions, | D | Due to (or as a | | | | | | | | | | |
| 68760, Micate be example of physician east the buriel | | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | G | | | | | | | 1 | | | | |
| S87 | dici | that initiated events resulting in death) Last | | Due lo (or as a c | conseque | nce of): | | | | | | | | |
| 5 0 4 | | | d | | 1 | | | | | i | | | | |
| death cert death cert death cert death cert | clan | | | | | 100 | | | | | | | | |
| 0 5 4 5 | Physician/Medical | Part II. Other significant conditions | contributing to death b | ut not resulting in | the und | erlying causa gi | ven in Part I. | | V | ntribute to the cause of death? | | | | |
| S, P. | by Pt | Diffeles | meu. | tus | | | | _ 1 | Yes 2 No | 3 Pro | bebly 4 Unknown | | | |
| Pording Penns Should | eted | Hyperte | nsion | | | | | 24a. Was | an autopsy omed? | av- | ere autopsy findings ailable prior to unpletion of cause death? | | | |
| I Rec | Omo | Hyperch | devero | lew in | _ | | | 10 | Yas 20 No | | ⊒Yas 2□ No | | | |
| f Vital I relean: The s cartificata director, pe | Be | 25. Was casa refarred to medical axaminer? | | | | | | Death (Check only | one) | | | | | |
| F 2 00 | 0 | 1 Yas 2 No | Hospital: 1 Inpatie | nt 2□ER/Ou | tpatient | 3LI DUA | | g Homa 5 Res | idence 6 □Oth | er (Specif | ý) | | | |
| Affing Ph Affer th funeral | ::0 | 27. Manuer of Death 1 Maturat 5 ☐ Pending | 28a. Data of Inju (Month, Da | y Year) 28b. 1 | lima of njury | 28c. Inju | | 28d. Describe | how injury occur | red | | | | |
| isi death | Certification: | 3 ☐ Suicide 6 ☐ Could not b | National investigation M 1[Suicide 6 □ Could not be 28e. Place of Injury - At home, farm, street, factory, office | | | | | | □ Yes 2 □ No 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) | | | | | |
| Divisit To the Heapital or Attent within 24 hours after desti To the Funeral Director: completaly filled in by the | edicai C | | nysician: To the best of miner: On the basis of and manner str | axamination and | | | | | | | | | | |
| To to the Foot | Σ | 29b. Signature and title of certifier | se number | 29d. Data signed (Month, Day, Year) | | | | | | | | | | |
| | | che | 111/19/10 | 7/ | | D | 6104 | | KDIVP | 47/ | , 2000 | | | |
| 1 | | 30. Nama and address of person who CHR I STOP HER | D. KRAK | NEY | M) | 700 | WASH | BUD. | BALT | ·n | 1, 21230 | | | |
| | State | 31. Data lifet (Month, Day, Year) | 32. Registro | ar's Signature | 10 | rocker | | | | | | | | |

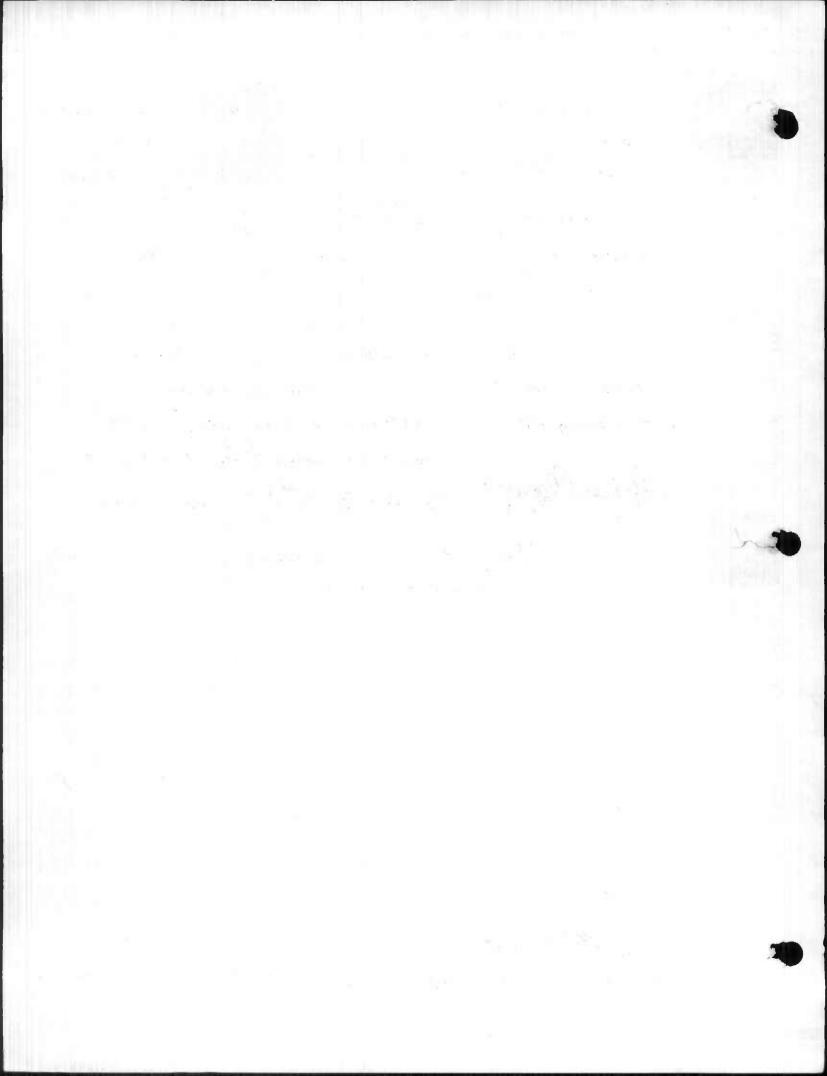
DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 021 51

| | | | | | Certif | icate of | Death | F | Reg. No. | UZ | 47 | 1 | | | |
|---|---|--|---|---|--|---|--|--|------------------------------|---|----------------------------|-----------------------|-----|------------|---------------|
| Physicia | _ | 1. Decedent's Neme (First, Middla, Las | st) | | 41 | | | 2. Dete of Dee | eth Dey | Yeer | 3. Time | e of Deeth | | | |
| Physicia Medica∕ | | Charles Stanle | y Bosley, | Jr. | | | | Jan. | | 2000 | 5:5 | 0 PM | | | |
| Examine | | 4a. Facility Neme (If not institution, give | street and number) | | | | 4b. City, Town, or | Location of Deeth | 4c. County | of Death | | | | | |
| | | Manor Care - | Ruxton | | | | Tows | on | Balt | imore | | | | | |
| Funeral Director | | 217 10 1401 | DM ODE | e (In yrs. 8 1 | | Under 1 Yee onths Days | | | y, Year) 8 1918 | 9. Birthpi Coun Ma | iace (Sta try) ryla: | te or <i>Foreig</i> n | | | |
| naturel', or items 23e or 28e-f show pical Expressor must be notified at | Director | Usual Residence of Decedent 10a. Stete 10b. County | | 10c. Cit | y, Town or Locati | on | | | | 141 | Od ineld | City Limits | | | |
| Sa-f short | | MD Baltin | nore | | Cockeys | | | | | | | as 2 No | | | |
| or 28 | | 10e. Street and Number | | | 1 | Of. Zip Code | | | 10g. Citizen of | Whet Coun | try? | | | | |
| 23a | | 205 Dawson Dr | • | | | 210 | 30 | | US | Α | | | | | |
| 9 | by Funeral | 11. Marital Stetus 1 Navar Married 2X Married 3 Widowed 4 Divorced | Armed Forces? | 1 ☐ Yes 2 🕱 No If Yes, Give | | | 13. Wes Decedent of Hispanic Origin? (Specif Yes, specify Cuben, Maxican, Puarto R | | 14. Rad Bia Specify | ce - American Indian, ck, White, etc. by: White | | P. | | | |
| lical . | ted | 15. Decedent's Ed (Specify only highest gree | ucation | | 16a. Decedent | 's Usuel Occu | ipation | rkina | 16b. Kind of B | usiness/Ind | dustry | | | | |
| 7 is marked other than "r traumatic event, the Mad | Completed | Elementery/Secondery (0-12) | Compti | | during most of wo | rking | Colleg | 0 | | | | | | | |
| after C | | 17. Fether's Name (First, Middle, Last) | 4 Comp | | | | | me (First, Middle, Maiden Sun | | | | | | | |
| 200 | o Be | | | | | | | | stelle Garrett | | | | | | |
| Tage 1 | 2 | 19e. informent's Neme/Reletionship (7 | | | 19h Meiling A | ddress (Stree | et end Number or Ru | | | State 7in | Code) | 1 | | | |
| T is | | Lillian L. Bosley/ | | | | | Dr., Coc | | | | 0000) | | | | |
| int: If frem 27 inty or other tri | 1 | 20e. Method of Disposition | WIIC | 20b. P | | | | Dete | 20c. Location | | wn. State | | | | |
| - 5 | | 1X Burlei 2 ☐ Cramation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify | | | Plece of Disposition (Neme of Detection or other place) 1/29/00 Lianey Valley Memorial Gardens 20c. Location - City or Town, State Timonium, MD | | | | | | | | | | |
| Important: I any injury o once. | | Signature of Funeral Service Light | arst | | 22. Na Lem | me end Addi | ess of Facility uneral He | ome | | | | | | | |
| | - | Bryan W. Ctar | y lications that caused | I the deat | Do not enter th | W. Pac | donia Rd. | , Timon | ium, M | D 210 | 93 Approxir | mata | | | |
| A - 1 | | 23a. Part 1. Enter the disaesa, or companion, or healt failure. List only of | one cause on each iii | 10. | ii. Do not enter ti | ie mode or dy | ing, soon as cardia | or raspitatory an | 1431, | | interval | | | | |
| ician dical | immediate Cause (Final disease or condition resulting in death) Due to (or es a consequence of): Cardio my park | | | | | | | | | Ad | (2 | | | | |
| niner | | diseese or condition resulting in deeth) | a cong | es11 | ve au | ed 1 | Scheme | C | | | 1 cer | illes. | | | |
| | Medical Examiner | edical Examiner | Examiner | uluer | | 0- | Due to (o | r es e consequen | ce of): | | | | | | |
| nsit | | | | | | 0. | | | | 7. | | | | | |
| el-tra | | | | Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseasa or injury | | Due to (o | r es e gonsequen | ce of): | | | | 1 | | | |
| | | | | | | Cause, Enter Underlying Cause (Diseasa or injury | | | | | | | i | | |
| the buriel-transit | | | thet initieted events resulting in deeth) Lest Due to (or as a consequence of): | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | |
| for use | | ysician | ysician | Physician | | | | | | | | | - 1 | | |
| ped 3 | | | | | ysic | ysic | ysic | Part ii. Other significent conditions contributing to death but not rasulting in the underlying cause givan in Part i. | | | | | | 23b. Did t | obacco uee co |
| K 70 I. | Dy Pu | | | | | | | 101 | /es 2□No | 3 Prob | oably 4 | Unknow | | | |
| | | | | | | | | 24e. Was | en autopsy | 24b. We | ere autop | sy findings | | | |
| should | completed | | | | | | | perfor | med? | COL | mpletion | or to of cause | | | |
| paga 2 | Ĕ | | | | | | | 400 | - offi | of death? | | etrafer. | | | |
| 7. p | 3 | 25. Wes case referred to medical | | | | _ | | 1 U Y | 7 | | I TOS 2 | No | | | |
| Leci Cer | 0 | exeminer? | Hospital: | | | 0 | thor . | eth (Check only o | | | | | | | |
| E - | - - | 27. Menner of Deeth | 1 ☐ Inpatie | | ER/Outpetient 3 28b. Time of | 3□ DOA O | | lome 5 ☐ Resid | | | () | | | | |
| funer | 0 | 1 Naturei 5 Pending investigation | 26a. Dete of Inju (Month, Daj | Year) | injury | 28c. inju We | ork?]Yes 2□No | | on injury coods | | | | | | |
| al Director: After i | erunca | 3 Suicida 6 Could not be determined | 28e. Piaca of injubuilding, etc | ury - At ho | ome, ferm, street, | | 1 - 4 1 - 6 - | 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) | | | | lumber, | | | |
| Funer staty fill | edical | 29e. Certifier (Check only one) Certifying Phy | sician: To the best of | examinet | wiedge, deeth oct tion end/or investi | curred et the t | ime, dete end place opinion, deeth occu | , end due to the c irred et the time, c | ceuse(s) and modele | enner es st end due to | ated. | se(s) | | | |
| To the Fu | Me e | 29b. Signature and title obcertifier | end manner sta | NOU. | | 29c Licen | ise number | | 29d. Date signe | d (Month | Day Van | r) | | | |
| 8 | - | Ess. Signature and title occument | 5/1.0 | | | | 12849 | | | | | , | | | |
| | | 11/10 | en work n | 47 | | 8 | 100 7 | | 1-27-00 TowsoN. Hel 21204 | | | | | | |
| 10,2 | | 30. Name end eddress of person who c | | eeth (Item | 23e) (Type, Prin | 1) | 11 % | 0 | 01/ 1 | 1.1. | 210 | 19 | | | |
| 12/ | | NH. GHILADI | · MD- | 76 | 00 8 | SLE | K DY | · 10WS | ON. M | OF I | 12 | 4 | | | |
| State | 9 | 31. Dete filed (Month, Day, Year) | 32. Registre | er's Signe | ture /. | / | 1 | | | | | | | | |



Please T

| Please Type or Print in Black Ind | lible ink. Assure All Copies Are Legible. |
|--|--|
| State of Maryland / Depart | ment of Health and Mental Hygiene 00 02452 |
| Cert | icate of Death Reg. No. |
| 1. Decedent'a Neme (First, Middle, Last) | 2. Date of Deeth 3. Time of Deeth |
| Margaret Eleanor Blizzard | January 31 2000 5:30AM |

Towson

4b. City, Town, or Location of Deeth

4c. County of Death

Baltimore

29d. Date signed (Month, Day, Year)

2000

| Physician |
|-----------|
| /Medical |
| Examiner |
| |

4a Facility Name (If not institution, give street end number)

Manor Care Ruxton

Funeral

Director

'natural', or items 23s or 28s-f show the Medical Examiner must be notified at filed within 72 hours after Dan Dan Mental

Baltimore, Maryland 21215-0020 Pages 1 and 2 should be d in a Department of Health Important: If Item 27

Physician /Medical Examiner

Physician/Medical Examiner The law requires that the death certificate be executed and use as the signed by by 8 funeral director, page 2 should Be Completed

Box 68760,

P.O.

of Vital Records,

Division

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica edicai Certification: To filled in by completely

If Under 1 Yeer If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthdey) 1□ M 2□ F 77 Yrs. Sept. 15 1922 Maryland 219-12-9701 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Directo MD. Baltimore Lutherville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 805 Kellog Rd. 21093 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, Black, White, etc. 12. Was Decedent Ever in U,S Armed Forces? 11. Meritai Status 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: 1 ☐ Never Merried 2 ☑ Married 1 ☐ Yes 2 ☑ No Specify: Specify: þ 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Coilege (1-4or 5+) +5 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Louise Albert J. Fredrich Berry 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Neme/Relationship (Type, Print) 805 Kellog Rd. Lutherville, MD. 21093 Mr. Dennis F. Blizzard/Husband 20b. Plece of Disposition (Neme of cemetery, crematory or other plece) 20c. Location - City or Town, State 20a Method of Disposition Dete 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) 2-3-00 Westminster, MD. Westminster Cemetery 21. Signature of Funerel Service Licensee 22. Name and Address of Fecility Ruck Towson Funeral Home, Inc. au 1050 York Rd. Towson, MD. 21204 23a. Part1. Enter the disease, or complicators that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onaet and Deeth Immediate Cause (Finel disease or condition resulting in death) DEHYDRATION Due to (or es e consequence of): END STAGE PARKINSONS DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequence of): Due to (or es a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Wes en autopsy performed? 25 No 1 Yes 2 No 1 Yes 25. Was case referred to medical examiner? 26. Piece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Netural 1 Yes 2 No 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stele) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the ceuse(s) and menner steted. 29e. Certifier

DHMH 16 Rav 6/95

State

Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

FEB 0 1 2000

FURNACE

GLEN

NA

32. Registrer'a Signeture

ROAD

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

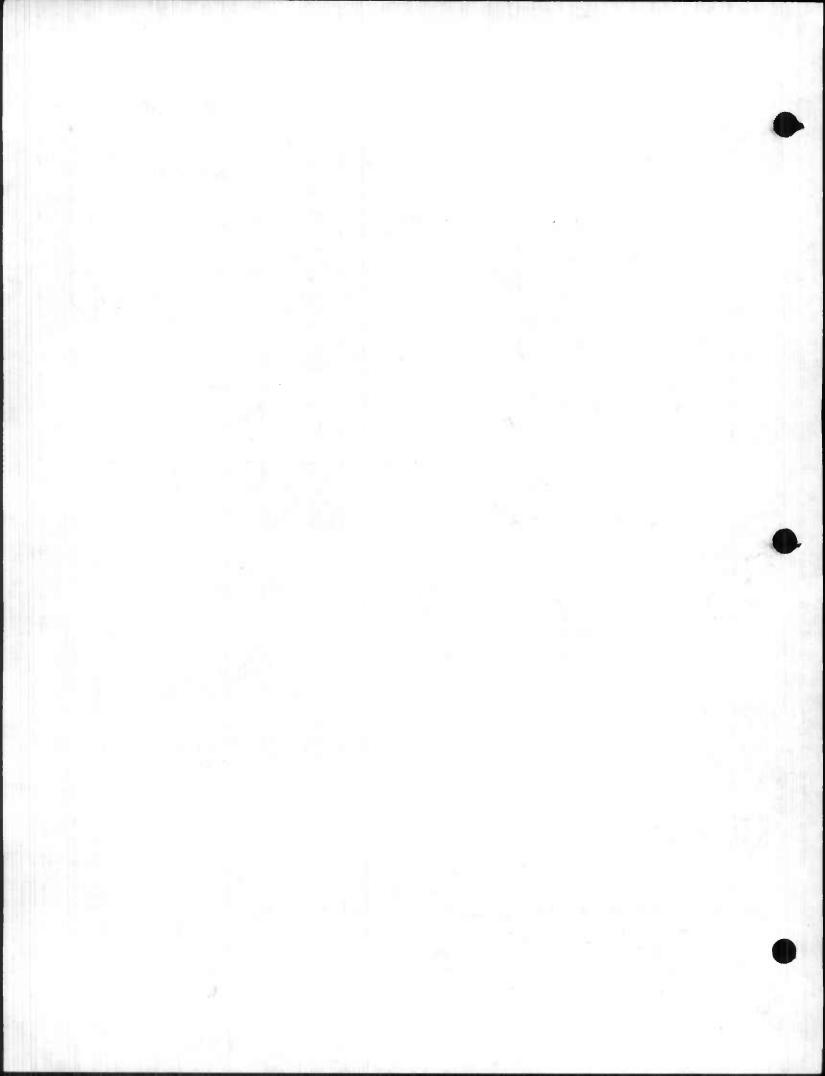
BRANCH

29c. License number

D54352

HIRCEA TOSOR

BURNIE



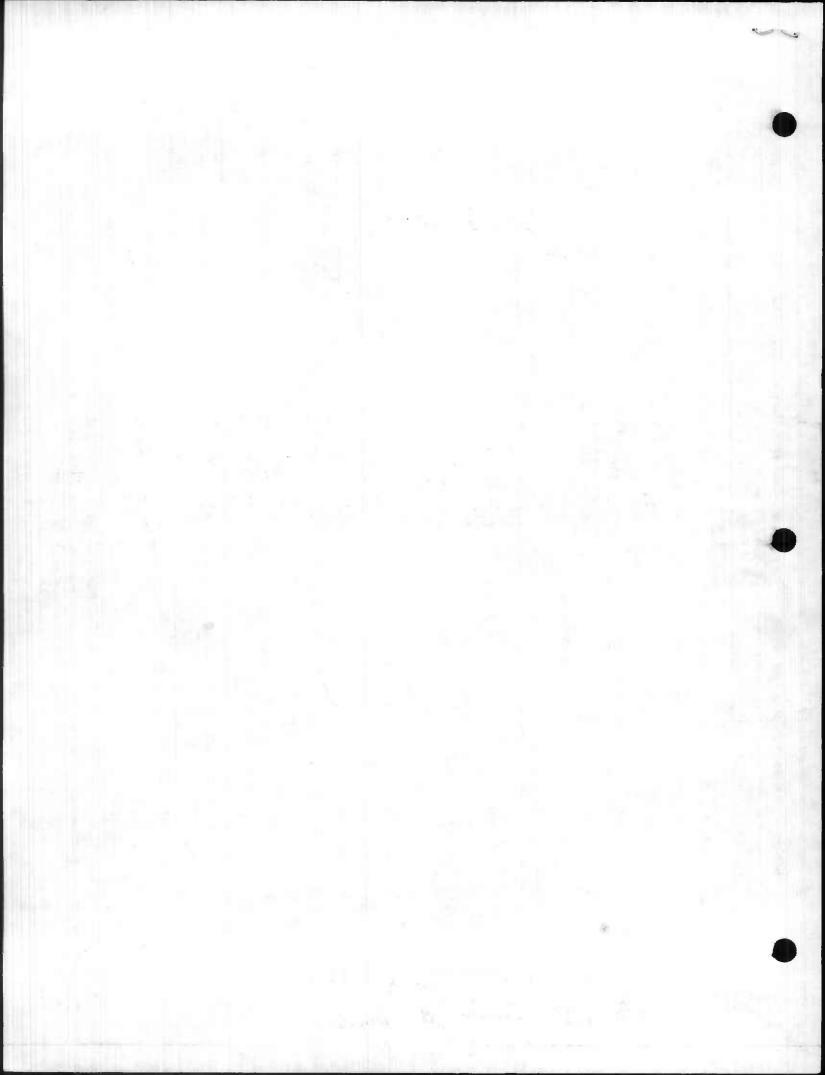
DHMH 16 Ray 6/95

State

Registrar

FEB 0 1 2000

Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 1 2 4 5 4

Patrick L. Blickenstaff Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Deeth 3 Time of Death Year Month **Physician** Patrick Blickenstaff 24, 2000 January 5:00 A.M. /Medical 4e Facility Name (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner Deaton Specialty Hospital Baltimore N/A If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) Aug. 10,1957 Maryland 5. Sociel Security Number 7. Aga (In yrs. lest birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 10 M 20 F 219-74-5851 Yrs **Director** Usual Rasidence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Exercines must be notified at MD 1 Yes 2 No **Baltimore** Catonsville Funeral Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 21228 U.S.A. 702 Crosby Road 14. Raca - American Indian, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanto Origin? (Specify Yas or No-If Yas, specify Cuben, Mexican, Puerto Rican, etc.) 11 Marital Status filed within 72 hours after 1 Yes 2 No
If Yes, Give
Yeer or Detes: 1 Never Married 2 Merried Baltimore, Maryland 21215-0020 White 1 Yes 2 No à 3 Widowed 4 Divorced Be Completed 16a. Decedant's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Auto Mechanic 17. Father's Nema (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Ie marked otheny or other traumatic event Doris Bunty Melvin L. Blickenstaff 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Doris Boucher (Mother) 702 Crosby Road, Catonsville, MD 20b. Plece of Disposition (Name of cametery, cremetory or other pleca) 20c. Location - City or Town, Stete 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removel from State 1/29/00 Baltimore, Maryland Most Holy Redeemer 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Witzke Funeral Homes, Inc. 21. Signature of Fungral Service Licensee 1630 Edmondson Avenue, Catonsville, MD 21228 ad the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Intervet Between Onsat and Death Martin APPROVED BY MEDICAL EXAMINER **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical 7 Days Sepsis Examiner Due to (or es a consequence of): 3 Months Examiner Urinary Tract Infection Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events Due to (or es a consequence of): Box 68760, Neurogenic Bladder 15 yrs. plus Physician/Medical thet initiated events resulting in death) Last Dua to (or as a consequence of) the P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contributs to the cause of death? 1 Yes 2 No 3 Probably 4√3 Unknown Brain Stem Injury, Aphasia, Quadraplegia Records, by Completed 24b. Were eutopsy findings 24e. Wes an autopsy performed? available prior to completion of cause of death? 2 No 1 ☐ Yes 2 ☐ No 1 Yes Division of Vital after death.

Director: After this certifica 25. Was case referred to medical 8 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 1 Yes 2 No Medical Certification: To 28d. Describe how injury occurred Subject was in 28a. Dete of Injury (Month, Day Year) 27. Menner of Death 28b. Time of Injury 28c. Injury at Work? 5 Pending investigation 1 Netural unknown M 1 ☐ Yes 2 ☐ No 1976 2 X Accident a motor vehicle accident. 28e. Plece of Injury - At home, ferm, street, lectory, offica building, etc. (Specify) 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide unknown unknown To the Hospital within 24 hours of To the Funeral C completely filled Hospital 1XXX Dertifying Physician: To the best of my knowladge, deeth occurred et the time, date and piece, end due to the cause(s) end menner es stated.

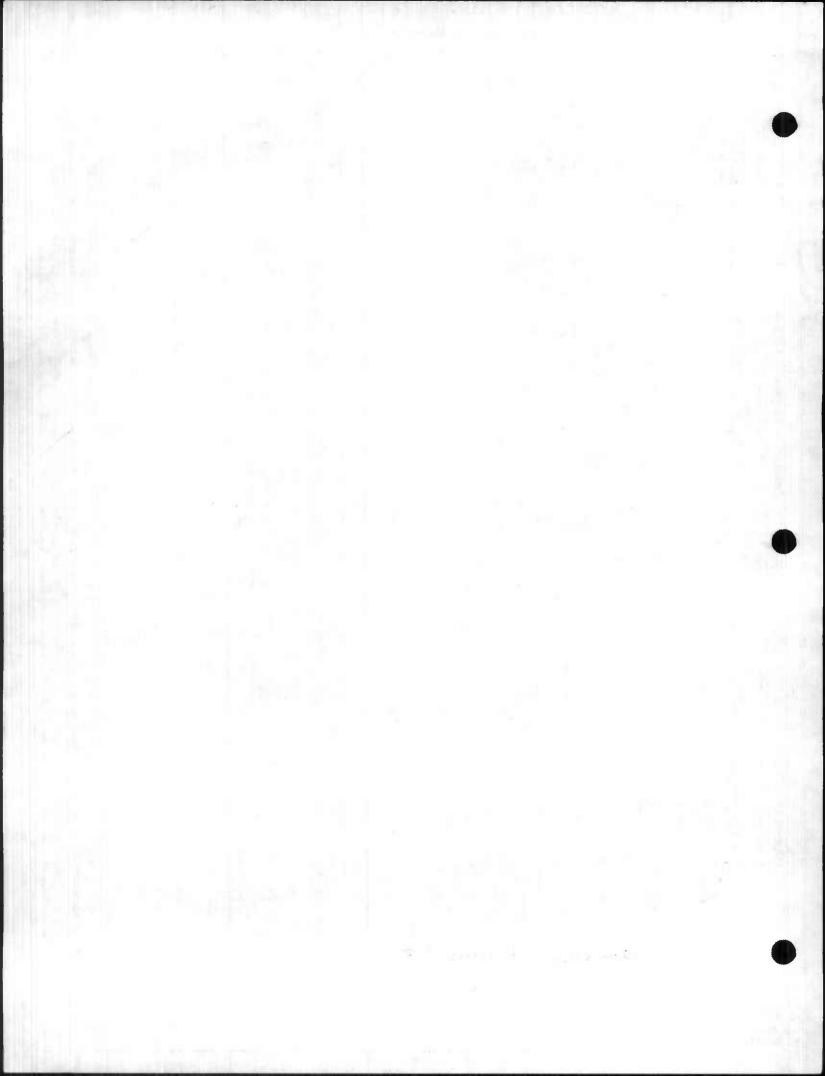
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Dete signed (Month, Day, Year) 29b. Signatura and title of certifier D01346 January 26, 2000 amerp.6. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) James Flynn, M.D., Deaton Specialty Hospital, 611 S. Charles St., Balto., MD 21230 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture

Registrar

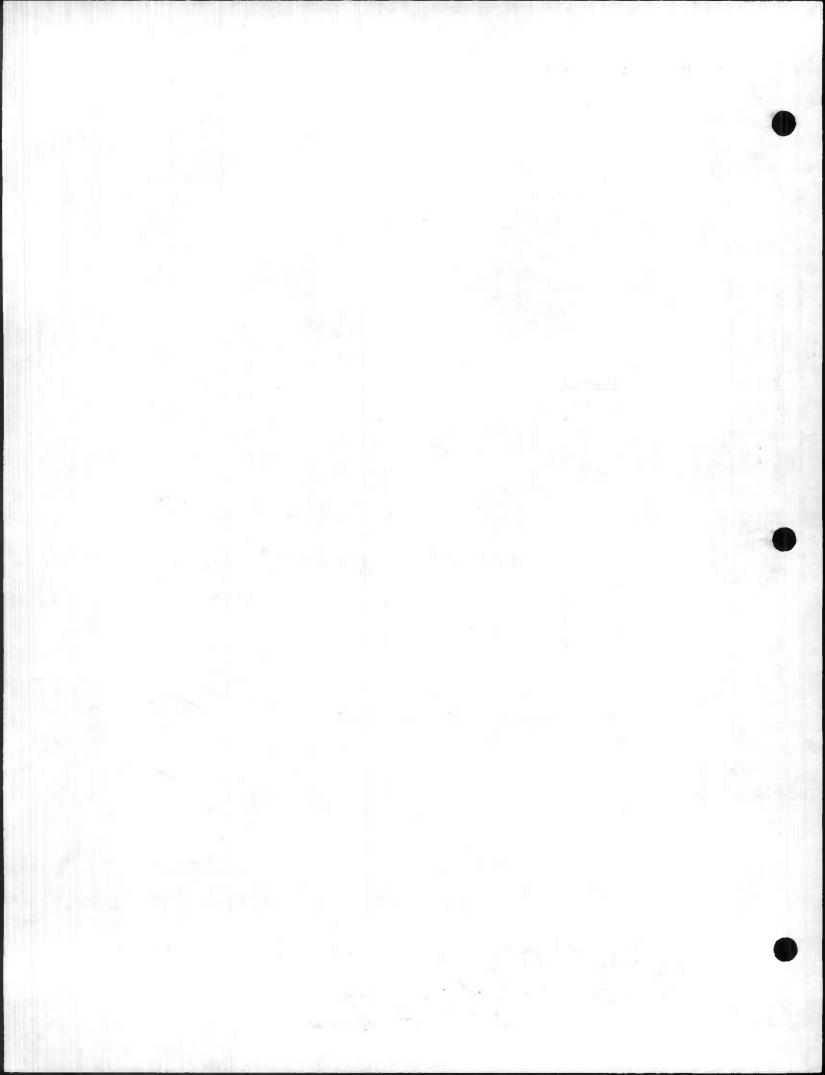
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FEB U 1 2000

Docks



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amended Items#23apt1,2 perPhyG780 2/1/2000 EW 1. Decedent's Name (First, Middle, Last) 2. Date of Death January 26, 2000 **Physician** Walter Bernell Barrack 2:00 A.M. /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Glen Burnie 57 Mapledale Avenue Anne Arundel 8. Date of Birth (Month, Day, Year) Nov. 13, 1933 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1X M 20 F Virginia Director 216-30-9757 the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show 1 ☐ Yes 2 No Funeral Director Md. Anne Arundel Glen Burnie 10g. Citizen of What Country? 10e Street and Number 10f. Zio Code me 23a or death with 57 Mapledale Avenue 21061 U.S.A. Reme ; 12. Was Decedent Ever in U.S. Armed Forcea? 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, r than "natural", or item the Medical Example: Black, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 21215-0020 1 Yes 2 No Specify: Completed by 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hyglene. Elementary/Secondary (0-12) College (1-4or 5+) i. Pages 1 and 2 should be filed witness of Health end Mental Hyglen tant: If item 27 is marked other thisury or other traumatic event, the Carpenter Self Employed Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edwin Barrack Edna Ι. Ferrier 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2319 Neudecker Rd., Westminster MD 21157 Donna Kurtz (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 □ Cremation 3 □ Removal from State Department of Important: If any Injury or Dates. Glen Haven Memorial Park1/29/00 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses McCully-Polyniak Funeral Home, P.A. 237 E. Patapsco Avenue Baltimore, Maryland 21225 nolma 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** LARYNX, CANCER /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificete be executed the burial-transi Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. physician Due to (or as a consequence of) 88 for use signed by the a d be detached f Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. 1 Tos 2 No 3 Probably 4 Unknown CANCLY CARDIOPULMONARY ARREST Completed by 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? page 2 has 1□ Yes 2□ No 1 Yes 2[] No certificate Division of Vital or Attending Physician: luneral director. Be 25. Was case referred to medical axaminer? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Assidence 6 Other (Specify) edicai Certification: To 1 Yea 2 No 1 | Inpatient 2 | ER/Outpatient 3 | DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After 1 Natural 5 Pending Inveatigation s after deeth. 1 ☐ Yes 2 ☐ No 2 Accident the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Placa of Injury - At home, farm, atreet, factory, office building, etc. (Specify) 3 4 Homicide filled in Hospital 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie completaly 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the F within 2 29b. Signature and title of certifier, 29c. License number 29d. Date signed (Month, Day, Year) >6 09 00 o completed cause of death (Item 23a) (Type, Print) South Nanover Street Baltimore, Maryland 21225 Jack Hong 3001 S filed (Month Day Year) 1 2000 State Registrar



Piease Type or Print in Black Indelible Ink. Assure Ali Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** JAMES L. BRYANT JANUARY 30 8:05 AM 2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HARBOR HOSPITAL CEN 76R BALTIMORE If Under 24 Hrs. Hours | Min. 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days 18 M 2□ F Months Director 236-52-4371 Nov. 15, 1934 West Virginia Usual Residence of Deceden 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show 1 Mayes 2 □ No Director Maryland N/A Baltimore 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? b Berns 23a 3617 S. Hanover Street 21225 U.S.A. 14. Race - American Indian, Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Bleck, White, etc. 72 hours after 1 ☐ Never Married 2 M Married "natural", or Baltimore, Maryland 21215-0020 1 Tyes 2 No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) 10 N/A Tractor Trailer Mechanic Oakley Company Pages 1 and 2 should be filed then of Health and Mental Hygin art. If Itsem 27 is marked other 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) 86 Burles Acres Bryant Grace Faulkner 19a. Informant's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Department of Health as Important: If them 27 is any injury or other trea 3617 S. Hanover St. Baltimore, Maryland 21225 Sandra E. Bryant (Wife)
20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) Greenmount Crematory 2/1/00 | Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
McCully-Polyniak Funeral Home, P.A. 237 East Patapsco Ave Baltimore, Maryland 21225 23a. Part Lenter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Finel LUNG CANCER MONTHS disease or condition resulting in deeth) Examiner Examiner the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of): physician Box 68760 Physician/Medical Due to (or as a consequence of): the 980 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 Yes 2 No 1 Yes 2 No or Attanding Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Daath 28a. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. fnjury at Work? 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No death. Director 3 ☐ Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) n 24 hours after d ne Funeral Direct pletely filled in by 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

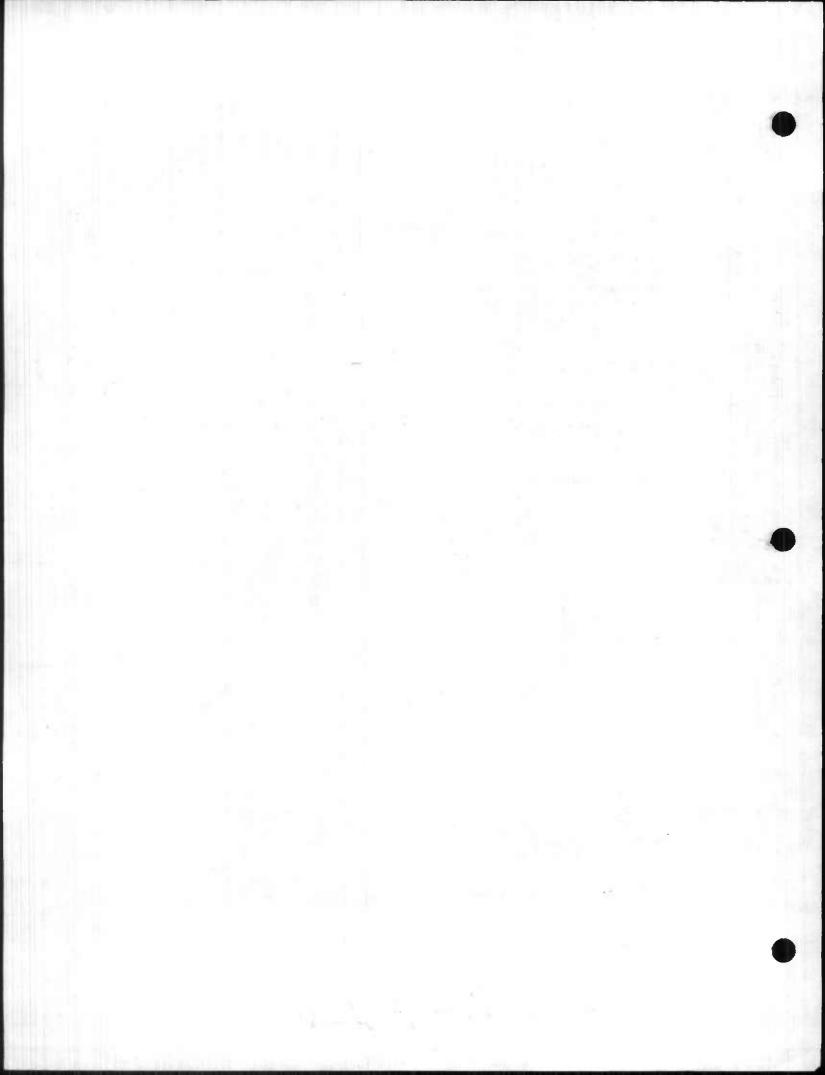
Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only one) To the I within 2 29b. Signature and 114 29c. License number 29d. Date signed (Month, Day, Year) of certifier RESIDENT. D0055481 JANUARY 30 2000 30. Name and address of person o completed cause of deeth (Item 23a) (Type, Print) SOUTH HANDUER 3001 STREGT SHWE MRA GYAW BALTIMOIZE

State Registrar

DHMH 16 Rev 6/95

31. Date filed (Month, Day Year) 1 2000

32. Resistrer's Signature

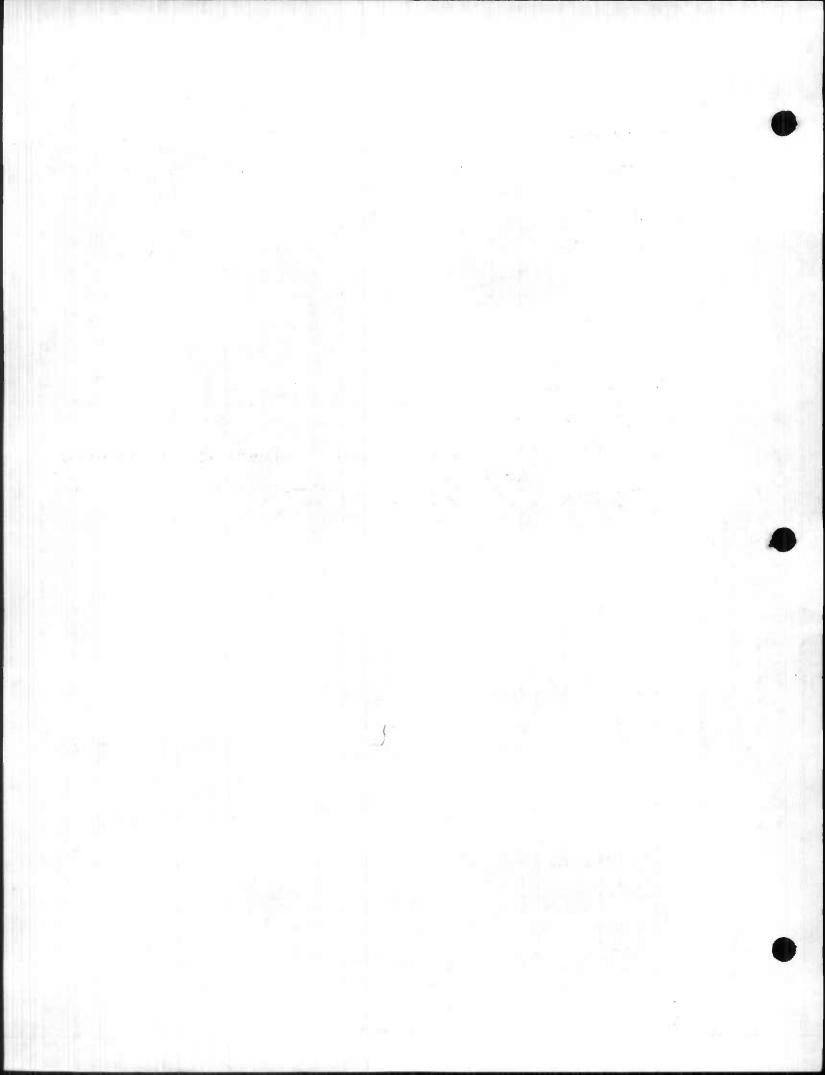


Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death January 26, 2000 **Physician** James E. Borkoski 7:00 A~ /Medical 4b. City, Town, or Location of Death 4c. County of Death 4e Facility Nama (If not institution, give street and number) Examiner 1310 Haubert Street Baltimore City If Under 24 Hrs. Hours Min. If Under 1 Year 5. Social Security Number 7. Age (In vrs. last birthday) 8. Dete of Birth (Month, Day, Year) April 7, 1943 9. Birthplace (State or Foreign **Funeral** Months Deys 1 MM 2□ F 214-01-0703 56 Maryland Director Usual Residence of Decedent the Menyland 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at Maryland N/A Yes 2□ No Baltimore City Directo 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 1310 Haubert Street 21230 United States Funeral death 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2,50No If Yas, Give Yeer or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexicen, Puerto Rican, atc.) 14. Race - American Indien 11. Meritel Status permit. Peges 1 and 2 should be filed within 72 hours effer c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item eny injury or other treumatic event, the Head and Exempted Black, White, atc 1 Never Merried 2 ☐ Married Baitimore, Maryland 21215-0020 1 ☐ Yes XX No Specify: White Specify: by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementery/Secondery (0-12) NA Disabled 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) John J. Borkoski, Sr. Margaret C. Peterson 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret C. Borkoski / Mother 1310 Haubert Street, Baltimore Maryland 21230 20e. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Steta DCBurial 2 Cremetion 3 Removel from Stete Cedar Hill Cemetery January 29, 2000 Baltimore Maryland 4 ☐ Donetion 5 ☐ Othar (Specify) 21. Signature of Funerel Service Licensee Victor P. Doda, Jr. 22. Name end Address of Fecility Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore Maryland 23a. Pert1. Enter the disease, or complications that caused the teath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. Approximete Interval Between Onset and Deeth **Physician** Immediata Cause (Finel disease or condition resulting in deeth) /Medical ACUMONIA Examiner Due to (or as a consequence of): Physician/Medical Examiner · Unknun l'time Clichence ettending physician end for use es the burial-transit that the death certificate be executed Sequentially list conditions, if any, laading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or es a consequence of): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Acriety Records, þ The law requires Chronic Obstruction Polmoney Disease 24b. Were autopsy lindings available prior to completion of ceuse of death? Completed 24a. Was an autopsy 1 Yes 2 No 1 ☐ Yas XX No certificate of Vitai Be 25. Wes case referred to medical 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home XXX Residence 6 Other (Specify) 1 Yes 35 No edical Certification: To this 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Division or Attending 5 Pending investigation 1 Netural deeth. 1 ☐ Yes 2 ☐ No 2 Accident Director: 3 Sulcide 6 ☐ Could not be determined 28a. Plece of Injury - At homa, larm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) To the Hospital or Att within 24 hours after d To the Funeral Direct completely filled in by 4 | Homicide IXCertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29e. Certifier (Check only one) 29d. Dete signed (Month, Day, Year) 29b. Signeture and title of certifier 29c. License number 053283 January 28, 2000 30. Neme and address of person who completed ceuse of death (Item 23a) (Type, Print) Christopher Ish, M.D. 1147 South Hanover Street, Baltimore Maryland 21230 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 16 Rev 6/95

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. 02458 State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month Yaar Jan. 27, 2000 7:50 am Charles Ellwood Bowie 4e Facility Nama (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death Good Samaritan Hospital Baltimore If Under 24 Hrs. If Under 1 Year 8. Data of Birth (Month, Day, Year) Aug. 8, 1954 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) Days Hours Months 12 M 20 F 218-60-2719 45 Maryland Usual Rasidanca of Decedant 10a State 10d. Inside City Limits 10b. County 10c, City, Town or Location 1 Was 2 □ No N / A Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21213 2036 E. Lanvale Street U. S.. 12. Was Decedent Ever in U,S. Armed Forces? 1 □X2as 2 □ No If Yes, Giva Yaar or Datas: Was Decedent of Hispanic Origin? (Specify Yas or Notif Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Raca - Amarican Indian, 11. Marital Status Afro-American 1 Nevar Married 2 Married 1 Yas 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highast grade completed) 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Businass/Industry Elementary/Secondery (0-12) 9Th College (1-4or 5+) N baker Bakery 17. Fathar's Name (First, Middle, Lest) 18. Mothar's Nama (First, Middla, Maiden Surnama) Leon Bowie Edna Mae Saunders 19a. Informant's Name/Reletionship (Type, Print) 19b. Meiling Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 5206 Leith Road Apt. Phyllis Frederick C Balto, Md. 21239 /Sister 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 Burial 2 Cramation 3 Removal from State Arbutus Memorial Park 2/3/00 Baltimore Md. Donation 5 ☐ Other (Specify) Signatura of Funaral Sarvice Licensee 22. Nama and Addrass of Facility Calvin B. Scruggs Funeral Home 23a. Part1. Entar the disaasa, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on agent inn. Md.21213 Approximata Intarvat Between Onset and Death Immediata Cause (Final disaasa or condition resulting in death) year mmunadeficiency Syndrome Havanced Acquired Sequentially list conditions, if any, laeding to immadiata causa. Entar Undarlying Cause (Diseasa or Injury that initiated evants rasulting in death) Last Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use centribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Wara sutopsy findings svailable prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 Yas 2 No 25. Was case refarred to medical 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Rasidenca 6 Othar (Specify) 1 Yes 2∏ No 1 Inpatient 2 DER/Outpatient 3 DOA 27. Menner of Death 28a. Data of Injury (Month, Day Year) 28d. Dascribe how injury occurred 28b. Tima of 28c. Injury at Work? 5 Pending 1 Natural NA 1 ☐ Yas 2 ☐ No invastigation 2 Accident N 6 Could not be detarmined 3 Suicide 28a. Ptace of Injury - At homa, farm, street, factory, office building, afc. (Specify) 281. Location (Street and Number or Rural Routs Number, City or Town, State) 4 ☐ Hornicide 112 Certifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date and piece, and due to the cause(s) and manner stated. (Check only one)

Physician /Medical Examiner Box 68760 P.O. Records, Division of Vital ò

signed by the e certificate Attending Physician: After n 24 hours after death.

The Funeral Director: After pletely filled in by the fun Hospital To the Hosp within 24 hos To the Fune completely fi

Physician

/Medical

Examiner

Funeral

Director

28a-f show

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items 23s

'natural', or

Hygiene.

Department of Health and Mental Hygie important: if Nam 27 is marked other 1

filed within 72 hours ofter

Baltimore, Maryland 21215-0020

the Medical Examiner must be notified at

Director

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Completed

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Examiner

Physician/Medical

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Completed

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Certification: To

Medical

physician and the burial-transit

080

DHMH 16 Rav 6/95

State Registrar

31. Data filed (Month, Day, Year) FEB 0

29b. Signature and title of certifier

ATRICIA

BARDITCH 32. Registrar's Signatura

MU

30. Name and andress of person who completed cause of death (Item 23a) (Type, Print)

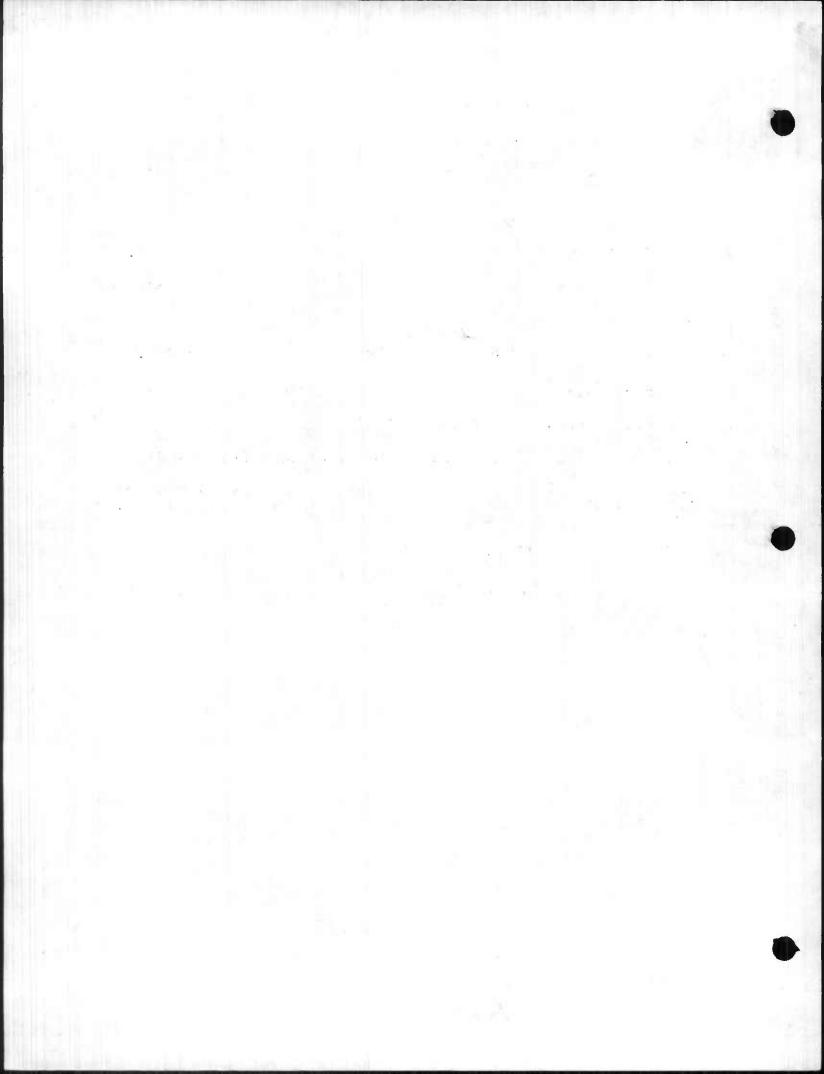
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29c. License number

29d. Data signed (Month, Day, Year)

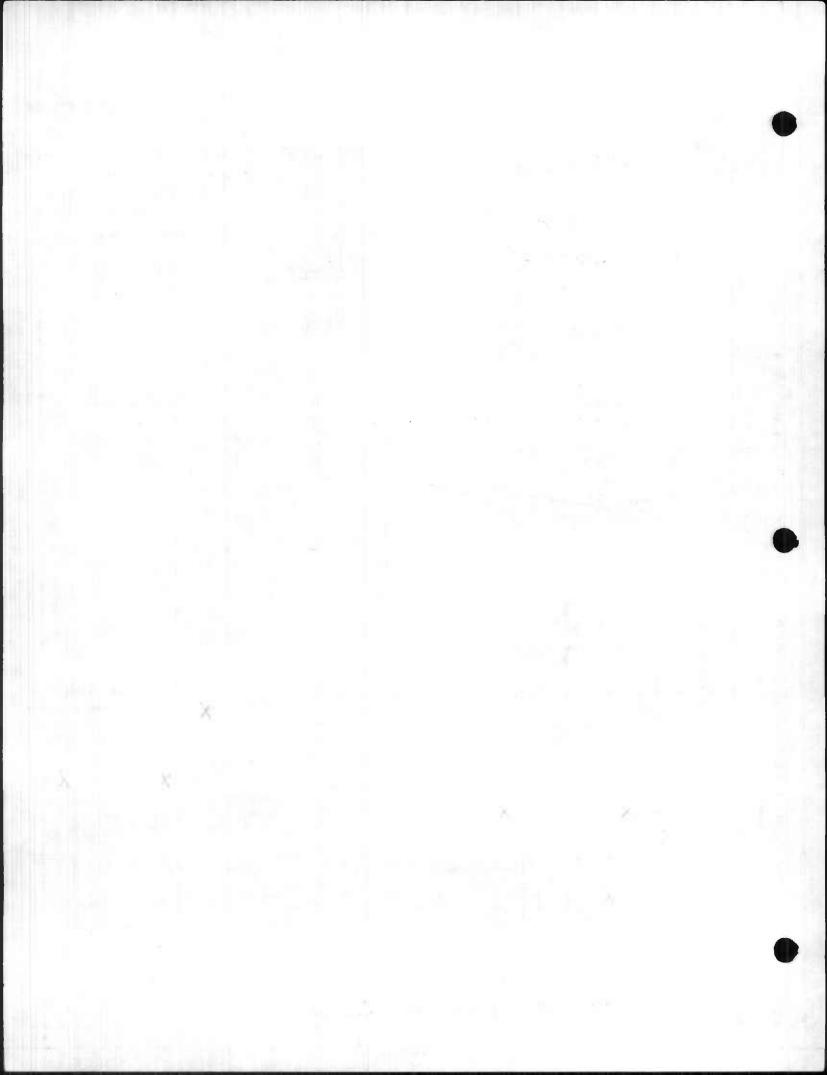
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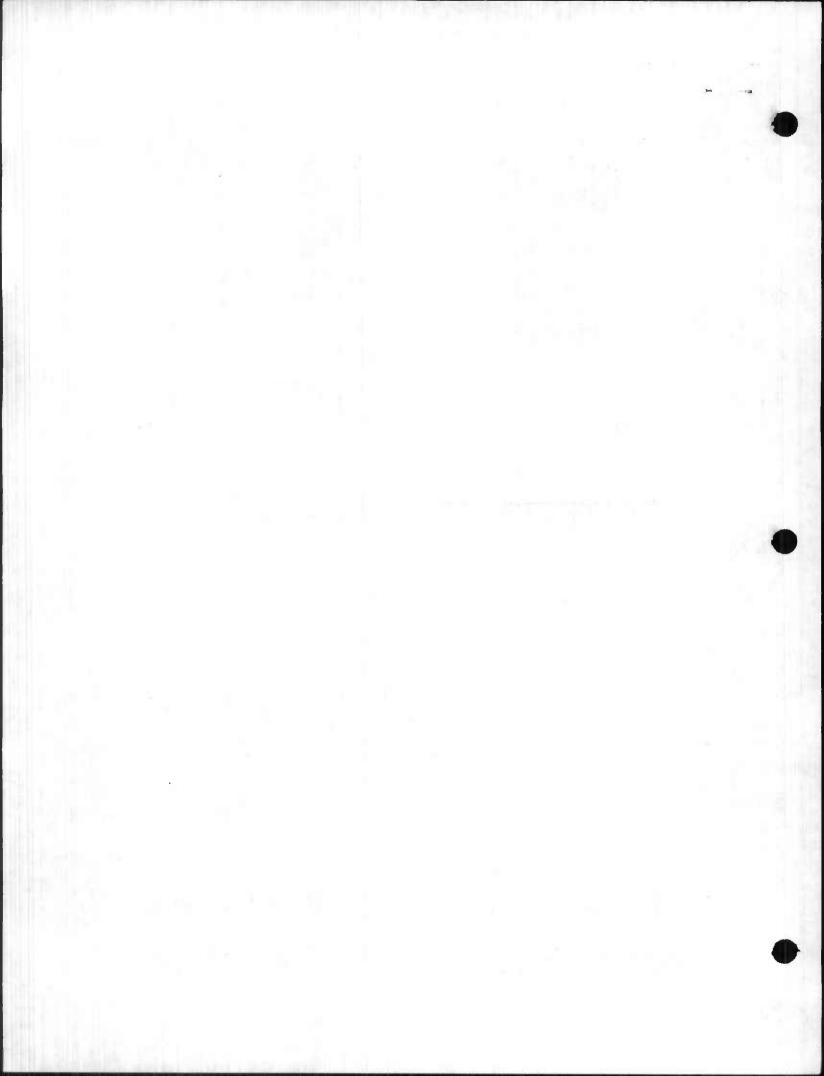
| S | tate of | Maryland / | Department | of Health | and | Mental | Hygien |
|---|---------|------------|------------|-----------|-----|--------|--------|

| | | | Certificate o | f Death | Reg | 3. No. | 0 051 | 159 | | | |
|---|--|---|--|--|--|---------------------------------|--|-------------|--|--|--|
| D | 1. Decedent's Name (First, Middle, | ast) | ALC: NO | | 2. Date of Death Month | Day | 3. Tima | of Death | | | |
| Physician /Medical | MAURICE W. B. | ALDWIN, SR. | | ANUARY | | 2000 7:0 | MA DE | | | | |
| Examiner | 4a Facility Name (If not institution, Saint Joseph | we street and number) Medical Cen | ter | 4b. City, Town, or Lo | | 4c. County | of Death Baltimor | .6 | | | |
| Director By Funeral Director | 5. Social Security Number 6 216–12–6569 Usual Residence of Decedent | Sex 17. Age (In yrs. 77 | last birthday) If Under 1 Yes Wonths Day | | 8. Date of Birth (Month, Day, 1) 5/29/22 | | 9. Birthplace (State Country) MARYLAND | e or Foreig | | | |
| | 10a. State 10b. County | 10c, Cit | y, Town or Location | | | | 10d, Inside | City Limits | | | |
| | MD DALETT | | | | | 1 ☐ Yes 2 ☑ No | | | | | |
| | MD BALTI 10e. Street and Number | YORE | TOWSON 10f. Zip Code | | 10 | a. Citizen of W | Shet Counter? | 71 | | | |
| | | 2012 | | | | USA | | | | | |
| | 1517 PROVIDENCE | ROAD 12. Was Decedent Ever in U. | | 286 Hispanic Origin? (Spe | cify Yes or No- | | A e - American Indian. | | | | |
| "natural", or iten ideal Employ leted by Fun | 1 Never Married 2 Married 3 Widowed 4 Divorced | Armed Forces? | If Yes, specify Co | uban, Mexican, Puerto | Rican, etc.) | | k, White, etc. | | | | |
| Completed | 15. Decedent's (Specify only highest) | | 16a. Decedent's Usual Occ | cupation ne during most of worki | 10 | 6b. Kind of Bu | siness/Industry | | | | |
| To Be Comple | Elementary/Secondary (0-12) | College (1-4or 5+) | life. DO NOT use reti | ired) | | | | | | | |
| TO CO | | 6 YEARS | ATTORNEY | ., | | SELF E | MPLOYED | | | | |
| other treumatic avent, | 17. Father's Name (First, Middle, La | st) | | 18. Mother's Name | (First, Middle, Ma | aiden Sumem | e) | | | | |
| To | H. STREETT BAL | OWIN | | MARY SN | HTI | | | | | | |
| 5 | 19a. Informant's Name/Relationship | (Type, Print) | 19b. Mailing Address (Stre | et and Number or Rura | I Floute Number, | City or Town, | State, Zip Code) | | | | |
| | BETTY L. BALDWI | N WIFE | 1517 PROVIDI | ENCE ROAD | TOWSON, | MD 21 | 286 | | | | |
| 5 | 20a. Method of Disposition 1€XBurial 2 ☐ Cremetion 3 | ☐Removal from State | Place of Disposition (Name of cometery, cremetory or other p | | | | City or Town, Stata | | | | |
| Injury | 4 Donation 5 Other (Spe | 27 | ESTNUT GROVE | 1 | /2000 JACKSONVILLE, MD | | | | | | |
| eny In | 21. Signature of Funeral Service Licensee 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 21286 | | | | | | | | | | |
| dical miner | Part Firter the disease, or continuous, or heart tailure. List on Immediate Cause (Final disease or condition resulting in death) | CHRONIC OF | BSTRUCTIVE F | | | | Onset ar | | | | |
| use as the burlet-transit | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | С. | or as a consequence of): or as a consequence of): | | | | | | | | |
| # ö = | Part II. Other significant conditions | contribution to death but not me: | niven in Part I | 23b. Did tobacco use contribute to the cause | | | se of death | | | | |
| be detached for us by Physician/ | | . # | Yes 2 No 3 Probably 4 Unknow | | | | | | | | |
| 2 should | | | | | 24a. Was an performe | | 24b. Were autopo available pri completion of death? | or to | | | |
| Page | | | | | 1 ☐ Yes | 2 No | 1 🗆 Yes 2 | No | | | |
| 0 0 | 25. Was case referred to medical | | | 26. Place of Death | (Check only one | | | | | | |
| | examiner? | Hospital: Inpatient 2 | ER/Outpatient 3 DOA | Other | me 5 ☐ Residen | | er (Snecify) | | | | |
| | 27. Manner of Death 1 Natural 5 Pending 2 Accident investigat | 28a. Date of Injury (Month, Day Year) | 28b. Tima of tnjury 28c. In | | 28d. Describe hov | | | | | | |
| To the Functal Director: After the completely filled in by the functal Completely filled in by the functal Medical Certification: | 3 Suicide 6 Could not 4 Homicide determine | | ome, farm, street, factory, offic | 88 | 28f. Location (Stre City or Town, | | er or Rural Route N | umber, | | | |
| pletely fille | 29a. Certifier 1X Certifying I (Check only one) 1X Medical Ex | Thysician: To the best of my known in the basis of examination and manner stated. | wledge, death occurred at the tion and/or investigation, in my | time, date and place, a pointion, death occurr | and due to the cau ed at the time, dat | use(s) and ma e and place, a | nner as stated. and dua to the caus | e(s) | | | |
| N Somp | 29b. Signature and title of certifier | | | nse number | | | Month, Day, Year | | | | |
| | | of D. de Les | | 508 | | Jan. | 28,20 | 00 | | | |
|) | 30, Name and address of person wh NATIVIDAD D. I | o completed cause of death (Item OE LEON, M.D. | , 7601 OSLE | R DRIVE, | TOWSON | , MD ; | 21204 | | | | |
| State Registrar | 31. Date filed (Mooth Pay, Year) FEB 0 1 2 | 32. Hogistrar's Signa | ture G. Spark | 2 | | | | | | | |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible

| | | 2/1/2000 AH | | | Certificate | of Death | | Reg. No. | | |
|---|--|--|--|--|--|--|--|--|---|--|
| /sician | Decedent's Nar | me (First, Middle, La: BEATRI | | | | CONN | 2. Date of Dec Month JANUAR | Day | Year 3. Time of Deeth | |
| ledical | 4a Facility Name | | e street and number) | | | | r Location of Death | | 1111 | |
| iner | | | RN PARKWAY | | | BALTIMO | ORE | | N/A | |
| | 5. Social Security 214–66 | | ex 7. Age | e (In yrs. lest b | irthday) If Under 1 Months D | Year If Under 24 Hi Days Hours Min | | h y, Year) 5 1909 | Birthplece (State or Foreign Country) MD | |
| | Usuel Residence | | | 30 | | | run. z | 3/1309 | PID | |
| Director | 10a. Stata MD | 10b. County | /A | 10c. City, Tov | wn or Location BALTIM | ORE | | | 10d. Inside City Limits 1X Yes 2 □ No | |
| | 10e. Street and N | umber | A colling in | | 10f. Zip Co | ode | | 10g. Citizen of V | Vhat Country? | |
| | | | RN PARKWAY | | | 21210 | | U.S.A. | | |
| | 11. Maritel Status | | 12. Was Decedent I Armed Forces? | - 112111 | 13. Was Deceden If Yes, specify | t of Hispanic Origin? (Cuban, Maxican, Pue | Specify Yes or No- irto Rican, etc.) | - 14. Raci | a - American Indian, k, White, etc. | |
| | 132 37 17 17 17 | rried 2 Married 4 Divorced | 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates: | NO | 1 ☐ Yes 2 🖸 | No Specify: | 70.00 | Specify | WHITE | |
| | (Spe | 15. Decedent's Ecelly only highest gra | lucation 16a. Decedent's Usual O (Give kind of work d life. DO NOT use n | | | done during most of w | orking | 16b. Kind of Business/Industry | | |
| - | Elamentary/Sec | condery (0-12) | College (1-4or 5 | | OMEMAKER | | OWN HON | 4E | | |
| 17. Father's Name (First, Middle, Last) | | | (a) | 1 1703 EM PHILLIC | | 18. Mother's N | ama (First, Middle, | Maiden Sumeme) | | |
| | MAX | | | BLUM | | | 4 | RAPPEPORT | | |
| | 19a. Intormant's I | Name/Ralationship (| | | | Street and Number or I | | | | |
| | | RET HIMEL | FARB / DAU | - | | W ROAD - E | T | | | |
| | | sposition Cremation 3 5 Other (Specifi | | 20b. Place cemete | ot Disposition (Name ery, cremetory or othe | of or place) | Date | 20c. Location - | City or Town, Stata | |
| 21. Signature of Funeral Service Licensee RONALD S WADE, 22. Name and Address of Facility STATE ANATOMY BOARD | | | | | | | | | | |
| | DIRECTOR 655 W. BALTIMORE ST BALTIMORE, MD 21201 | | | | | | | | | |
| | 23a. Part1. Enter | the disaasa, or com | plications that caused one cause on each lin | tha daath. Do | | t dying, such as cardi | | | Approximata Intervel Between | |
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| | The second secon | | | | | | | | Onset and Death | |
| | Immediete Cause disease or conditi | ion | e con | 15851 | 41VE 145, | ART FA | /LK | | 4 HAR | |
| | Immediete Cause disease or conditi resulting in death | ion | a. Com | 1555 f | LIVE ITE | ART FA | / K | | 4 hand | |
| | disease or condition resulting in death | jon) | | | | ART FO | /K sease | | 4 HAR | |
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| | disease or condit resulting in death Sequentially list of if any, leeding to causa. Enter Unc Cause (Disease of that initiated even | conditions, immediate derlying or injury | c | Due to (or as a | consequence ot): | ART FA | sease | | 10 95 OR | |
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| o confidence of the social succession of the | disease or condit resulting in death services of tany, leeding to causa. Enter Unc Cause (Disease of that initiated even resulting in death) Pert II. Other algorithms of the causa of the | conditions, immediate derlying or injury ats) Last | c. d. ontributing to death by Like Lu | Due to (or as a Due to (or as a ut not resulting | consequence ot): in the undarlying cause Dank as | sa givan in Part I. | 23b. Did 1 24a. Wes perfo | 10bacco use co Yes 2 No en sutopsy rmed? | htribute to the cause of death 1 0 9 5 000 1 0 9 5 000 24b. Wera autopsy findings available prior to completion of cause of death? 1 Yes 2 No | |
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| | disease or condit resulting in death. Sequentially list of any, leeding to cause. Enter Uncause. Disease othat initiated even resulting in death. Pert II. Other sign. 25. Was case rete examiner? 1 Yes 2 27. Manne of Dee | conditions, immediate deriving or injury its its interest to medical investigation of Could not be conditions of Could not be conditions. | c. d. contributing to death by the contributing to death by the contributing to death by the contribution of the contributio | Due to (or as a Due to (or as a ut not resulting ant 2 ER/O | in the undarlying cause Dutpatient 3 DOA Time ot Injury | 26. Place of D Other: 4 Nursing Injury at Work? 1 Yes 2 No | 23b. Did 1 24a. Wes perfo | 10bacco use colored version v | htribute to the cause of death 1 0 | |
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| Medical Certification: To Be Completed by Physician/Medical Examiner | disease or condit resulting in death resulting in death of it any, leading to causa. Enter Unc Cause (Disease of that initiated even resulting in death resulting in death of the causal | erred to medical served to medical ath S Pending investigation C Could not be determined | d. Ontributing to death by R C 5 5 5 Hospital: 1 Inpatie 28a. Date of Injunction, Depth of the building, efforts on the basis of the part of of the | Due to (or as a Due to (or as a ut not resulting ut not resulting 2 ER/C iny y Year) 28b. tury - At home, 1 c. (Specify) t examination a | outpatient 3 DOA Time ot Injury M farm, streat, tactory, of the decired at individual stream of the d | 26. Place of D Other: Injury at Work? 1 Yes 2 No office | 23b. DId 1 24a. Wes performed to the control of th | Tobacco use colored? Yes 2 No en sutopsy primed? Yes 2 No 3na) dence 6 □Oth how injury occur Straet and Number, State) ceuse(s) end medate and placa, | fitribute to the cause of death 3 Probably 4 Unknown 24b. Wera autopsy findings available prior to completion of cause of death? 1 Yes 2 No Per (Specify) Ted Per or Rurel Route Number, anner as stated. and dua to the cause(s) | |

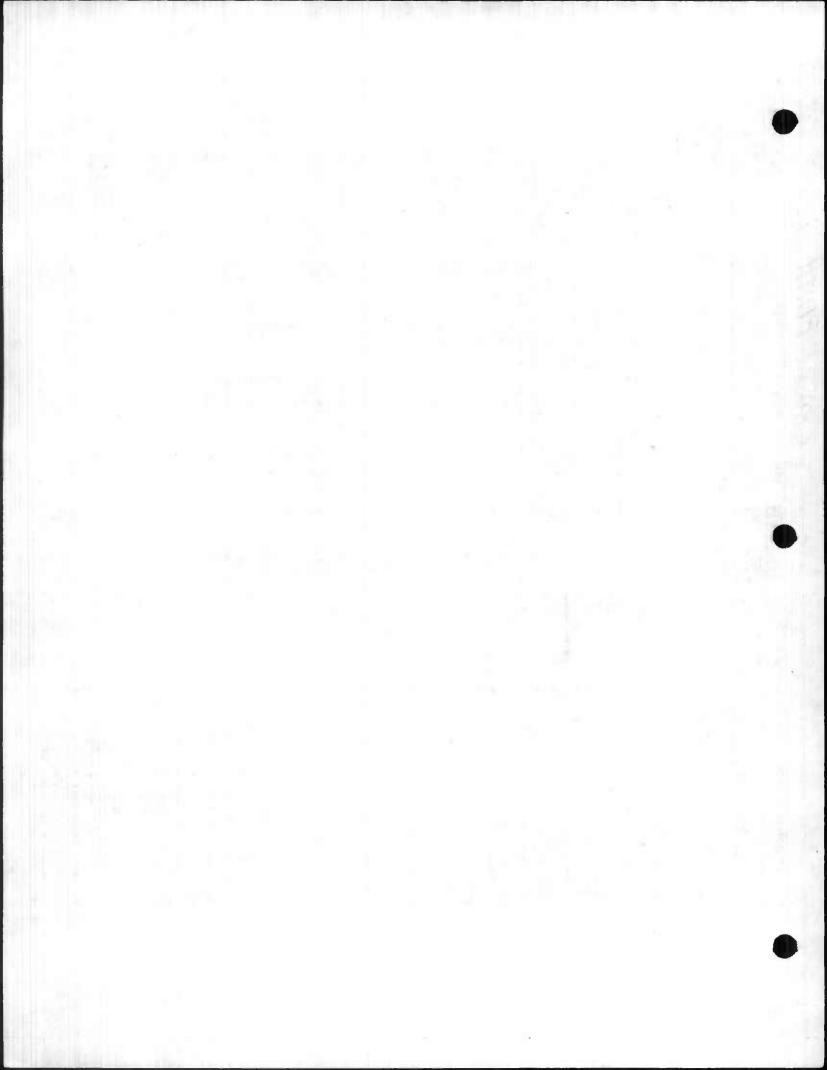


Please Type or Print in Black indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death January 28 2500 **Physician** 2:40 PM Edith Lorene Cross /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner North Arundel Hospital Association Glen Burnie Anne Arundel Hunder 24 Hrs. 8. Date of Birth (Month, Day 7 Year) August 7, 1931 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 9. Birthplace (State or Foreign **Funeral** Days 1 M 2 F Months Texas 455-40-3924 68 Director Usual Residence of Decedent 10s. Stata 10b. County 10c. City. Town or Location 10d. Inside City Limits Maryland Anne Arundel Glen Burnie Director 1 Yas 2 No 10f. Zip Code 21061 7120 East Furance Branch Road Apt. B 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Menia! Hygiene. Important: if item 27 is marked other than 'natural', or thems 23a or should be any injury or other traumatic avant, ma Heades Expenses and 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No If Yes, Giva Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married White 1 Yes 2 No Specify: P 3 ☑ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Surnama) Be John Richmond Unknown 19a. Informant's Name/Relationship (Type, Print) (daughter) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code)
Mrs. Rhonda Lynn Greenly 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code)
11434 S. Northwood Circle, Olathe, KS 6606 11434 S. Northwood Circle, Olathe, KS 66061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition 20c. Eccation - City or Town, Stata 1 ☐ Burial 2 IX Cremation 3 ☐ Removal from State Chesapeake Cremation Ctr. 2-1-00 Stevensville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Nama and Address of Facility Singleton Funeral Home, PA. 21. Signature of Euneral Service Licens 1 Second Ave. S.W. Glen Burnie, Maryland 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Intervat Between Onset and Death **Physician** tmmediate Cause (Final diseasa or condition rasulting in death) /Medical Examiner Examiner physician and the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Box 68760. Physician/Medicai P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No or Attanding Physician: Be 25. Was case referred to medical axaminer? 26. Place of Death (Check only one) Hospital: 1 Yas 2 No Other: 4 Nursing Homa 5 Residence 6 Other (Specify) edicai Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending invastigation To the Hospital or Attanding within 24 hours after death.

To the Funeral Director: After completely filled in by the fur 1 Yes 2 No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 3 ☐ Suicide 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

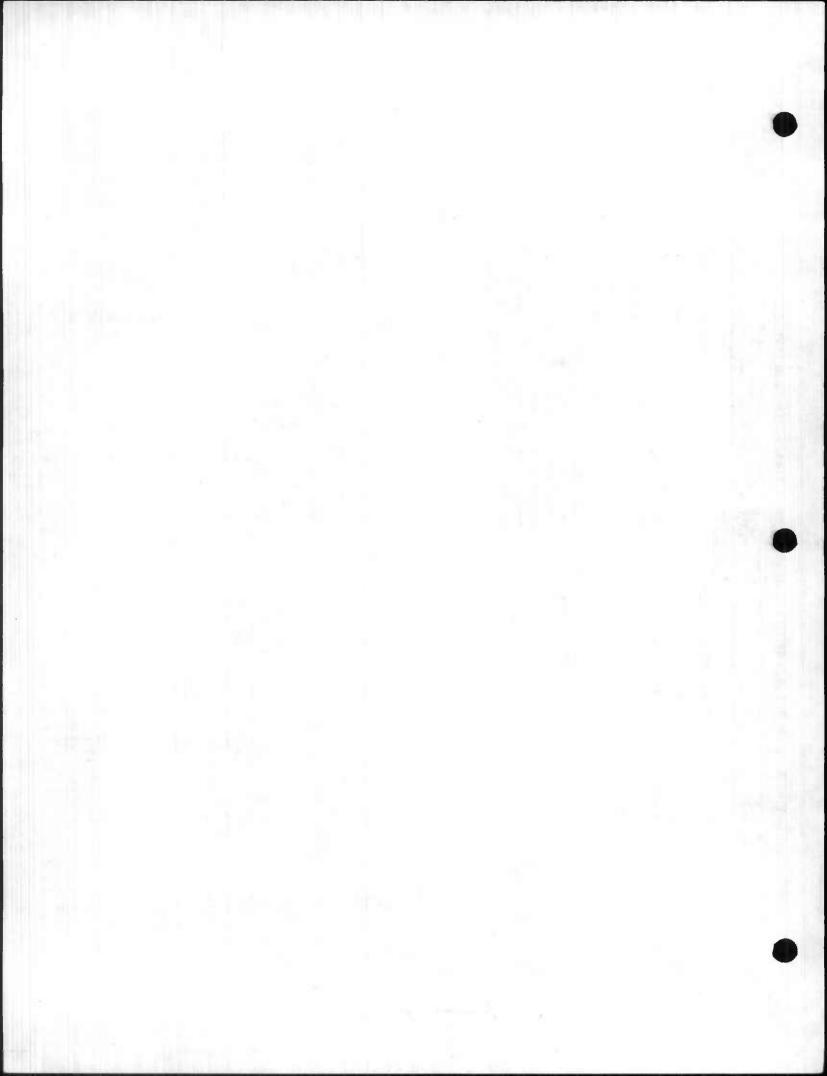
2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Data signed (Month, Day, Year) 29b. Signature and title of certified January 28, 2000 il II M.D. 301 Hospital Drive 21061 no completed causa of death (Item 23a) (Type, Print) 30. Name and address of person Wicks the 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Deper Registrar FEB 0 1 2000



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 0 24 6 2

| | | | | | Certi | ficate of | Death | | Reg. No. | , 0 | 6406 | | |
|--|----------------|--|---|--|--|---|---|--|---|---------------------------|---|--|--|
| | | 1. Decedent's Neme (First, Middle, Li | | 777 | | 0.00 | | 2. Date of De Month | ath | Vana | 3. Time of Death | | |
| Physicia /Medic | _ | SADIE | Ci | ALD | WEL | L | | JANUA | MY 272 | 7000 | 4 PM | | |
| Examin | _ | 4a Facility Name (If not institution, gi | | | | | | r Location of Deat | | | | | |
| | | NORTH WEST | HOSP | ITA | 2 | | | LUTOW | J MAR | YCA | NO | | |
| Funeral Director | | | · Class of the | ge (In <i>yrs. le</i> 30 | | If Under 1 Yes Months Dey | | | | 9. Birthpl Court | laca (Stete or Foreign try) | | |
| p . | - | Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location | | | | | | | | | Ad to 14- 0% 11-% | | |
| e Maryle le-f ahor | . 1 | MD BALTI | MORE | | TIMOR | | | | | | 0d. Inside City Limits 1 ☐ Yes 2√ No | | |
| after death with the Marylan or thems 23e or 28e-f show miner ment be notified as | 5 | 10e. Street and Number 10 TOMBER COUL | RT | | | 10f. Zip Code 2120 | | | 10g. Citizen of V | | try? | | |
| 0 5 4 | by Fur | 11. Meritel Stetus 1 Never Married 2 Merried 3 Widowed 4 Divorced | P No | | es Decedent of es, specify Cu | Hispanic Origin? ban, Mexican, Pue Specify: | Specify Yes or No erto Rican, etc.) | No- 14. Race - America Black, White, e Specify: BLA | | etc. | | | |
| 72 hours | e e | 15. Decedent's E (Specify only highest gr | ducation | 16a. Deceder | nt's Usuel Occ | upation e during most of w | orkina | 16b. Kind of B | usiness/Ind | lustry | | | |
| within the control of | Completed | Elementery/Secondary (0-12) | College (1-4or: | life. DO | NOT use reti | ROVIDER | O'A WING | HOME CARE | | | | | |
| | Be C | 17. Father's Neme (First, Middle, Last | | | 5.1.2.0 | | 17-1-2-2-2 | ame (First, Middle | | | | | |
| yian buld be Mental erked o | 0 | AMOS WASHINGTO | S WASHINGTON SALLIE | | | | | | | | | | |
| Maryland of should be flie th and Mental Hy ith and Mental Hy it is marked other traumatic avant | | 19a. Informent's Neme/Reletionship | et and Number or i | Rural Route Numb | lural Route Number, City or Town, State, Zip Code) | | | | | | | | |
| | - | KAREN LATSON - | DAUGHTER | • | 1 | | COURT | BALTO. | MD 2 | 21207 | 7 | | |
| 0 00 5 | | 20a. Method of Disposition PDBurial 2 □ Cremetion 3 □ 4 □ Donetion 5 □ Other (Speci | | Ce | ace of Dispositi metery, creme IG MEMO | tory or other p | , | Date 2-3-00 | 20c. Location - | | | | |
| pemil. Pag Department Important: I any Injury o | | 21. Signature of Funerel Service Lice | | | MA) | RCH FU | UNERAL I | HOME WE | ST, INC | | | | |
| | - | 23a Part Filler Indicasca or con | Collections that source | d the death | | | BASH AVE | | | 212 | Approximate | | |
| Dhualaina | | 23a. Part Enter the disease, or com shock, or hear ailure. List only | one cause on each li | ne. | . Do not enter | the mode of o | ring, such es cardi | ac or respiratory a | 11031, | | Intervel Between Onset end Deeth | | |
| Physician / / / / / / / / / / / / / / / / / / / | | Immediate Cause (Final | | | | 11 0441 | | | | | | | |
| Examiner | | disease or condition resulting in death) | | | | | | | | 1 | 11 DAYS | | |
| | Jer | | | Due to (or | as a conseque | ince oi): | | | | 1 | | | |
| ntificate be executed ng physician and as the burial-transit | Examiner | Sequentially list conditions, if any, leading to immediate | b | Due to (or | as a conseque | nce of): | | | | | | | |
| flicate be and g physician as the buriel | edical | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury thet imited ed events Due to (or as a consequence of): c | | | | | | | | | | | |
| W | 8 | resulting in death) Last | Due to (or as e consequence of): | | | | | | | | | | |
| death cert death cert attendin | Clar | | | | | | | 1 | | 1 | | | |
| of by the defected | Physician/M | Pert It. Other algorificant conditions of | elgnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. | | | | | | 23b. Did tobacco use contribute to the cause of d | | | | |
| | by Pl | PNEUMONIA | | | | 1 Yes 2 No 3 Probably 4 | | | | | babiy 4/2 Unknow | | |
| a has been signed by the age 2 should be detached | Completed b | , | | | | | | | an autopsy omed? | ava | ere autopsy findings allable prior to mpletion of cause | | |
| | de l | | | | | | | | 4 | of c | death? | | |
| F 4 4 | ខ្ល | | | | | | | 10 | Yes 217No | 10 | Yes 2 No | | |
| Physician: The laver this certificate has ral director, page 2 | 00 | 25. Wes case referred to medical examiner? | Hospitel: | | | 10 | | eath (Check only | one) | | | | |
| 4 3 5 | 2 | 1 ☐ Yes 2 ☐ No 27. Manner of Death | Inpatie | | P/Outpatient | 3LI DON | | Home 5 Resi | | | () | | |
| After funer | o ' | 1 ☑Netural 5 ☐ Pending | (Month, Da | 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. tnjury at Work? | | | | 28d. Describe | 28d. Describe how injury occurred | | | | |
| To the Hospital or Attanding I within 24 hours after death. To the Funeral Director: After completely filled in by the funeral | Certification: | 2 Accident investigetion 3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) | | | | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| To the Hospital within 24 hours To the Funeral completaly filled | | 29e. Certifier (Check only one) Check only one) | nysician: To the best of | examineti | rledge, deeth o | ccurred et the stigetion, in my | time, date end place opinion, death oc | ce, end due to the curred at the time, | cause(s) and made and place, | anner as st and due to | ated. the cause(s) | | |
| thin the | | 29b. Signature and title of certifier | and manner st | ated. | | 29c Lice | nse number | | 29d. Date signe | id (Month | Dev. Year) | | |
| F 3 F 8 | | D. C. Mu | i ho | | | | 3733 | 3 | JANYA | | | | |
| 0 | 3 | 30. Name and address of person who | completed cause of d | leath (Item | 23a) (Type, Pri | int) My | 2113 | 3 | | | | | |
| State | е | 31. Dete filed (Month, Day, Year) | 32. Registr | er's Signet | ure / | 1 | 2113 | | | | | | |
| Pogietra | | FFB 0 1 2 | /UUU \\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\ | Marchael | D. | Ann | Wal | | | | | | |



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State of Maryland / Department of Health and Mental Hygiene [] [Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 11:00am 25, 2000 James Owen Cullember January /Medical 4b. City, Town, or Location of Deeth 4e Facility Neme (If not institution, give street end number) 4c. County of Death Examiner 5547 Franklin Blvd. Churchton Anne Arundel If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) If Under 1 Year Birthplace (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months 1 M 2□ F 56 Yrs Director 214-44-3802 Dec. 28, 1943 Maryland Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location ahow 10d. Inside City Limits r than "natural", or itema 23a or 28a-f ahor tre Medical Examiner must be notified at 1 Yes 2 No Director Anne Arundel Churchton 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 5547 Franklin Blvd. 20733 USA Funerai 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. should be filed within 72 hours after and Mental Hygiene. 1 Never Merried 2 Married 1X Yes 2 No Baltimore, Maryland 21215-0020 If Yes, Give Yeer or Detes: 1966-71 1 Yes 2 No Specify: Specify: White by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 Heavy Equipment Operator Construction 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) . Peges 1 and 2 should be filt ment of Health end Mental Hant; If Nem 27 is marked oth Jury or other traumatic even Be Alvin Owen Cullember Marion Phipps 19e. Intormant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Donna P. Cullember (wife) 5547 Franklin Blvd., Churchton, MD 20733 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete permit. Peges Department of Important: If It any Injury or o Burial 2 □ Cremetion 3 □ Removel from Stete Jan 29, 4 ☐ Donetion 5 ☐ Other (Specify) Davidsonville, MD Lakemont Cemetery 21. Signeture of Funerel Service Licensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, 21401 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate tnterval Betw Onset and Deeth **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical 1-24 MARS · METASTATIC SARLOMA Examiner Due to (or as a consequence of): Examine physician and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Last Due to (or es a consequence of) 68760 The lew requires that the death certificate be Physician/Medical Due to (or es a consequence of): Box 980 P.O. Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 1 Yes 2 -No 3 Probably 4 Unknown BRUNARY ARTHRY X154451 þ Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed FIBRILLADON page 2 s 1 Yes 2 No 1 ☐ Yes 2 ☐ No of Vital 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Besidence 6 Other (Specify) 1 Yes 2 No 2 this 27. Menner of Death 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? edical Certification: I or Attending Patter death. After Division 5 Pending Investigation 1 Natural 1 Yes 2 No 2 Accident Director: / 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled 1 Orthying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

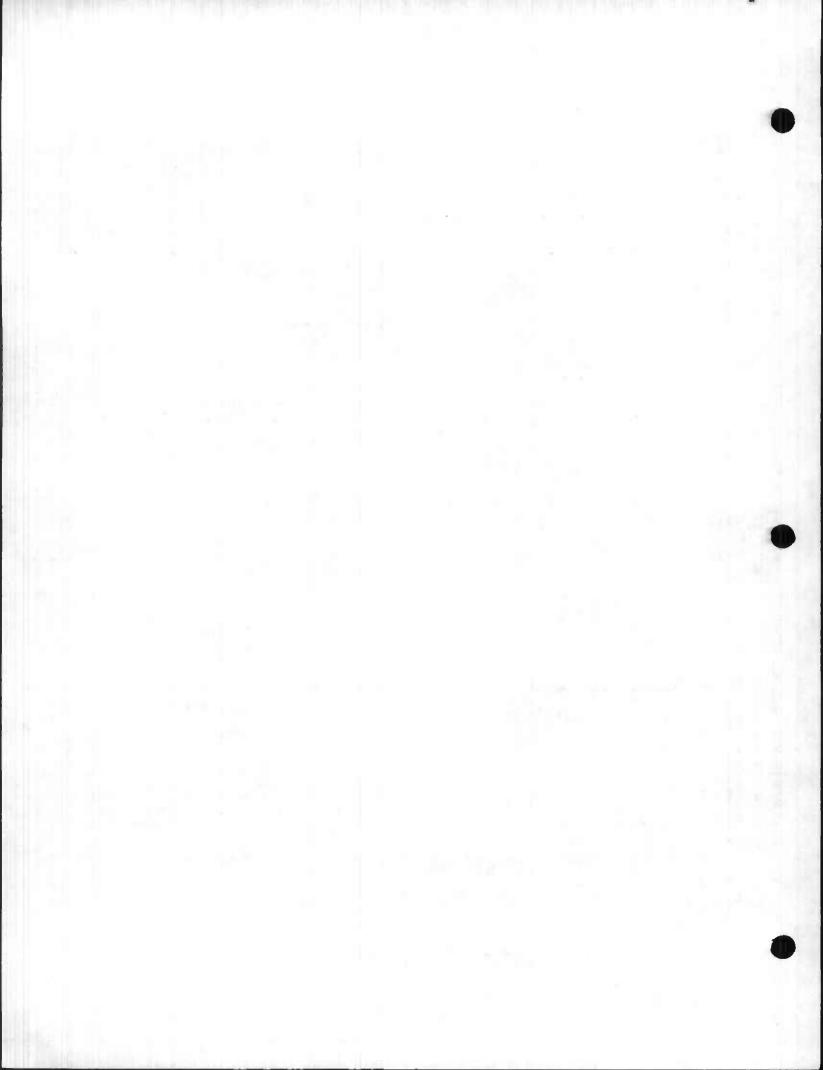
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title ot certifier 29c. License number D26358 JANUAR-1 27 2000 Rise 12 ress of person who completed cagse of deeth (frem 23a) (Type, Print) PRINCE FREDERICK MA-20678 MD JO1+ ~ (FIBE) 31-Onte 190 (Mpnt 19 PMYear) 32. Registrar's Signetura

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Registrar

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middla, Last) 2. Date of Death 3. Time of Death Dey 2 7 2000 **Physician** CUMMINGS 1:35 AM GERTRUDE ANNA JANUARY /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CENTER BALTIMORE HARBOR HOSPITAL If Under 24 Hrs. 5. Social Security Number If Under 1 Year 8. Data of Birth (Month, Day, Year Oct. 21, 191 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foraign Country) **Funeral** Days Months 1 M SOF Hours 216-24-7769 80 **Director** Usual Residence of Decedant 10a. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits ahoe nust be notified at 1√ Yes 2 No Baltimore City Directo WA MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21230 115 West Randall Street United States "natural", or flams 23s Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian, 11 Marital Status 12. Was Decedent Ever in U,S. Armed Forcas? Black, White, etc. atte 1 Yes 2 Total 1 Navar Married 2 Married altimore, Maryland 21215-0020 1 Yes XX No Specify: Specify: White ğ 3 Vidowed 4 □ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elamentary/Secondary (0-12) College (1-4or 5+) Own Home Homeneker 8 0 17. Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Surnama) d 2 should be fi th and Mental H 7 is marked of Be Unk. Parrish Martha (Unk. Maiden Name) Pages 1 and 2 should 19e. Informent's Name/Ratationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) opartment of Health an important: If them 27 is m any injury or other 200s. 1922 Wilmington Aveneu, Baltimore Maryland 21230 Charles A. Cummings / Son 20b. Place of Disposition (Nama of 20c. Location - City or Town, State 20a. Mathod of Disposition Date Buriat 2 Cramation 3 Removal from Stata 4 Donation 5 Other (Specify) Tiloham Methodist Cametery Assn. February 1, 2000 Tilghman Island, MD 21. Signature of Funaral Sarvice Licensee Victor P. Doda, Jr. 22. Name and Address of Facility Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore Maryland 21230 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximata Intarval Batween Onset and Death **Physician** /Medical Immediata Causa (Finai 3 DAYS PNEUMONIA disease or condition resulting to death) Examiner Dua to (or as a consequence of): Examiner physician and s the bunal-transit the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Dua to (or as a consequence of): Box 68760. Physician/Medical Dua to (or es a consequence of): Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 0 signed by I 1 Yes 2 No 3 Probably 4 Unknown CHRONIC OBSTRUCTIVE PULMONARY DISEASE Records, þ 24b. Wara autopsy findings available prior to 24a. Was an autopsy performed? Completed CONGESTIVE HEART FAILURE completion of cause of death? 1 Yes 2 No 1 Yas 2 No Division of Vital 25. Was casa raterred to medical axaminar? Be 26. Place of Death (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Residence 8 Other (Specify) 1 Yes 2 No Certification: To this 27. Manger of Death 28a. Data of Injury (Month, Day Year) 28b. Time of tnjury 28c. Injury at Work? 28d. Describe how injury occurred After 1 Netural oepital or Attending hours after death. 5 Pending Invastigation 1 Yes 2 No Director: / 2 Accident 6 Could not be datarmined 28f. Location (Street and Number or Rural Route Number, City or Town, Stele) 3 ☐ Suicida 28a. Place of tnjury - At home, ferm, street, factory, office building, atc. (Specify) 4 Homicide To the Hospital or A within 24 hours after To the Funeral Directompletely filled in by 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. edical 29a. Certifie (Check only one) 29b. Signatura and titla of certifier 29c. License number 29d. Data signed (Month, Day, Year) PGY-1 INTERN M. Farcel JANUARY 2000 P 13471 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

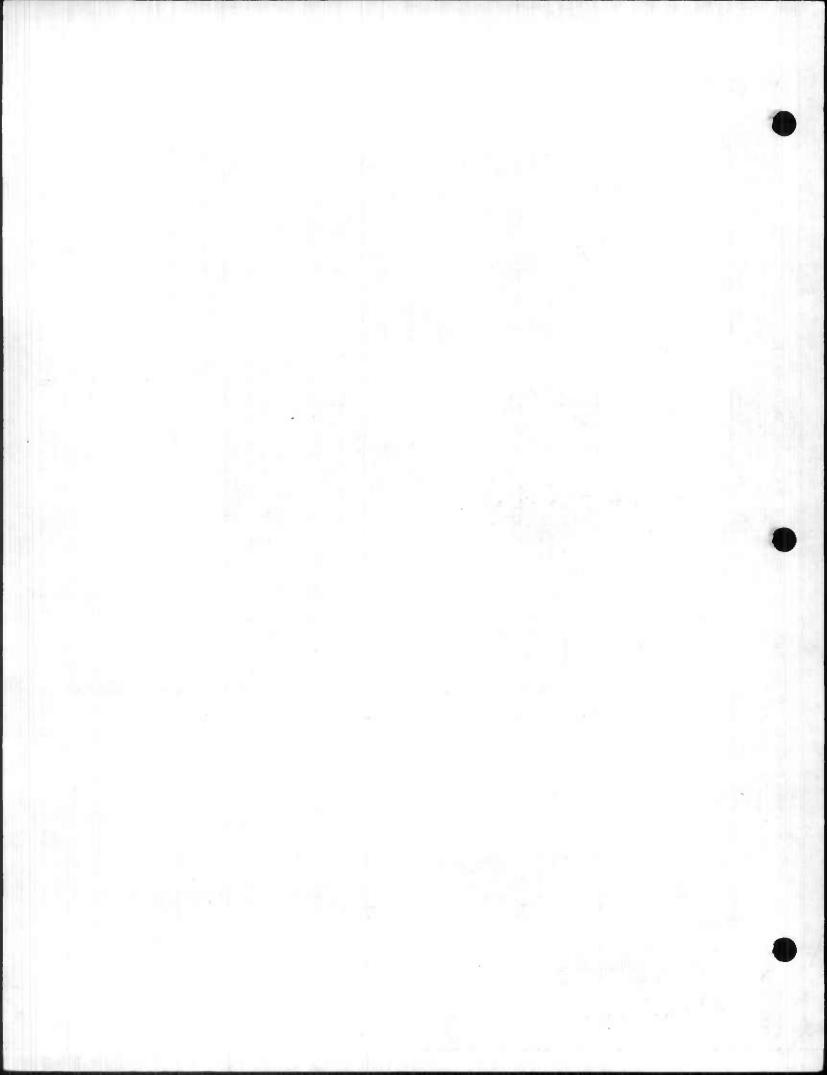
MARINA FARAH, M.D. 3001 S HANOVER STREET, BALTIMORE, MD 2/225 FARAH, M.D. 31. Data filed (Month, Day, Year) 32. Registrar's Signatura

Registrar **DHMH 16 Rev 6/95**

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Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death GRUPP Year 9.45an JOSEP H 2000 23 01 4e Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death BALTIMORE CITY N/A SINAI HOSPITAL 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) Months Deys Hours XI M 2 F 80 Yrs. 218-03-5194 1/29/19 MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No N/A BALTIMORE CITY 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6225 YORK ROAD USA APT. 407E 21212 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. XX Yes 2 No If Yes, Give Year or Detes: 1 ☐ Never Merried 2 ☐ Married 1 ☐ Yes 2 No Specify: WWII 3 Widowed 4 □ Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) CONTRACTOR 6TH GRADE STEEL 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surname) CHARLES GRUPP, SR. ELSIE KRATZ 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ELISE SCHRYVER DAUGHTER 2770 ALLSPICE ROAD POST REPUBLIC, MD 20676 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State GARDENS OF FAITH CEM. 4 ☐ Donation 5 ☐ Other (Specify) 1/29/2000 PARKVILLE, MD 21. Signature of Funerel Service Licenses 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. TOWSON, MD Approximate Interval Between Onset and Death Immediate Cause (Final ASPIRATION disease or condition resulting in death) BRO UASCE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Part If. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 10PA-24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medicat axaminer? 26. Placa of Death (Check only one) Hospital: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how Injury occurred 28c. Injury at Work? 1 Matural
2 Accident 5 Pending Investigation 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 6 Could not be 3 Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide

Examine Records, of Vital Division

Physician

/Medical

Examiner

Funeral

Director

must be notified at

"natural", or items 23a

I Hygiene.

Pages 1 and 2 should be fill ment of Health and Mental H lant: If Hem 27 is marked out

nt of Health a: If Item 27 is

Department of Important: If any Injury or pace.

Physician /Medical

72 hours after

Baltimore, Maryland 21215-0020

Director

Funeral

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Completed

Be

Physician/Medical

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Completed

Be

Certification:

edical

29a Certifier

To il. After death. attor 8 To the Hospital within 24 hours To the Funeral completely filled

State Registrar

DHMH 16 Rev 6/95

1838 GREENZ 31. Date filed (Month, Dey, FEB 0 1 2000

29b. Signature and title of certifier

30. Nama and address of person who completed cause of deeth (Item 23a) (Type, Print) TREZ 32 Registrar's Signature

KUUBIR SUITE 120

Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

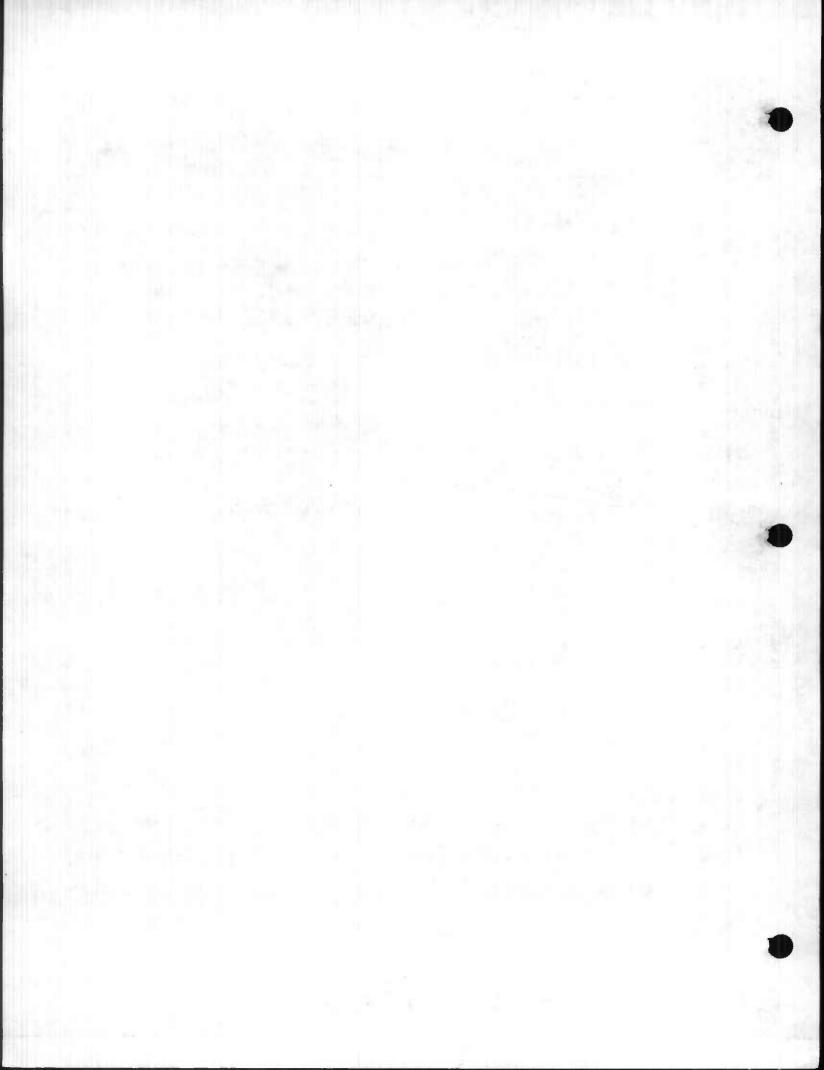
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29d. Date signed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 10 02466 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month 0 1 **Physician** PHYLLIS A CARR 0455 /Medical 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** ST. AGNES HOSPITAL Baltimore City 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 73 Yrs. Months Days Hours Min March 31, 1926 Virginia 5. Social Security Number 9. Birthplece (Stete or Foreign **Funeral** 212-20-6278 1□M 2MF Director Usuel Residence of Decedent 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23e or 28a-f ahow traumatic event, the Modical Examiner nausi be notified at the Meryle 1 Yes 2 No Director Halethorpe Md. Baltimore 10f. Zip Code 10g. Citizen of What Country? 21227 3925 Twin Circle Way U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 2 should be filed within 72 hours efter ond Mental Hygiene.
Is marked other than "naturel", or ite 1 ☐ Never Merried 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: White p 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupetion (Give kind of work done duning most of working life. DO NOT use ratired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) Coilege (1-4or 5+) Crown Petrolium Cashier 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Gertrude Rosalie Patrick James Claggett Rigger 19e. Informent's Neme/Reletionship (Type, Print) 19b. Melling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) permit. Peges 1 and 2 st Department of Health end Important: If item 27 is n any Injury or other traun 3925 Twin Circle Way, Halethorpe, Md. 21227 James C. Carr - Son 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete 1 XBuriel 2 Cremetion 3 Removel from State Maryland Veterans Cem. Feb. 4,2000 Owings Mills, Md. 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Facility

Eckhardt Funeral Chapel 11605 Reisterstown Rd., Owings Mills, Md. 21117 23e. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** /Medicai Immediete Cause (Final disease or condition resulting in deeth) · myocardal infaction how Examiner Due to (or es e consequence of): Zoyen disense Due to (of es e consequence of) physician end the burial-transit Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initieted events resulting in deeth) Lest Box 68760. Physician/Medical Due to (or es e consequence of) P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Tyes 2 No 3 Probably 4 Unknown Hypertension, Hypercholecterolenic Division of Vital Records, þ 24a. Wes an autopsy performed? 24b. Were eutopsy findings aveileble prior to completion of cause of death? Completed 1 ☐ Yes 2 No 1 Yes 2 ₽No 25. Was case referred to medical exeminer? Be 26. Plece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ EH/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 funeral 27. Menner of Death 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 1 Naturel 5 Pending il or Attending efter deeth. | Director; Aft 1 TYes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide Location (Straet and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide 24 hours e Funeral D 29a. Certifier 1 Cartifying Physician: To the best of my knowledge, deeth occurred et the time, date and pleca, end due to the ceuse(s) end manner as steted. (Check only one) 2 Madfcat Examinar: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, dete and place, and due to the cause(s) and menner stated. To the within 2.
To the F 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 100-MD B6-5448998 Januar 28, 2000 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) 0) Robert Greenhald 900 Caten August Ballmore, Md. 21229 32 Begistrar's Stanature Sports 31. Dete filed (Month, Day, Year)

DHMH 16 Rav 6/95

Registrar

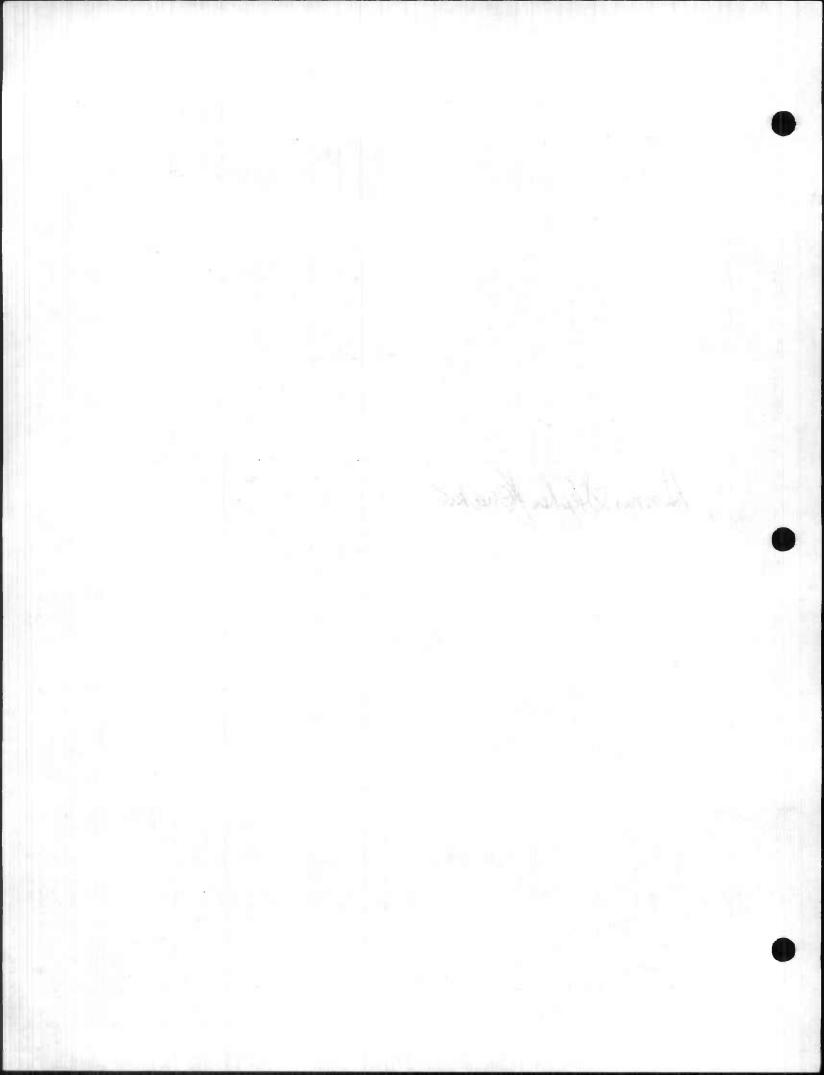
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dale of Death 3. Time of Death Month **Physician** MARGUERITE CRAMBLITT CHILLEMI 9:07AM January 29,2000 /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Stella MAris Hospice Timonium Baltimore If Under 1 Yeer If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthdey) 8. Dete of Birth (Month, Dey, Year) **Funeral** Days Months Hours Director 212-01-5489 December 6,1908 Maryland Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits show 1 ☐ Yes 2 ☐ No Directo 288-1 Maryland Baltimore Timonium 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 'natural', or items 23s or 2125 Suburban Green Drive 21093 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces?

1 Yes 2 Who If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 11. Maritel Stelus filed within 72 hours after 1 ☐ Never Merried 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes XX No Specify: Specify: White à 3 ☐ Widowed 4XX Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Legal Secretary Law permit. Pages 1 and 2 should be lies.
Department of Health and Mental Hyg.
Important: If Item 27 is marked other any Injury or other traumers once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be John Cramblitt Florence Gay Richardson 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) C. Gay Platania DTR 2125 Suburban Green Drive Timonium Maryland 21093 20b. Piece of Disposition (Neme of cemetery, crematory or other piece) 20c. Location - City or Town, Stete 20a. Method of Disposition Burial 2 Cremetion 3 Removal from Stete 2/1/00 Parkville, Maryland Donation 5 Other (Specify) Parkwood Cemetery ature of Funeral Service License 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc. 6500 York Road Baltimore, Maryland 21212 of compositions that ceused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximate Interval Between Onset and Death **Physician** Cerebrovascular Accident-/Medical Immediate Cause (Final diseese or condition resulting in death) Examine Examiner physician and s the bunal-transit that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medical Due to (or as a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yaa 2 No 3 Probably 4 Uhiknown signed i Records, by 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? page 2 s 1 Yes HINO 1 Yes 2 No Division of Vital 25. Was case referred to medicel examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Domer (Specify) HOSpice 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? After or Attending 1 Natural 5 Pending Investigation deeth. 1 ☐ Yes 2 ☐ No we Hospital or Attendit in 24 hours after deeth. we Funeral Director: A pletely filled in by the fo 2 Accident 6 Could not be determined 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Place of Injury - At home, farm, atreet, factory, office building, etc. (Specify) 4 ☐ HomicIde Medical 29a. Certifier 10 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner steted. within 2.
To the F 29d. Dete signed (Month, Day, Year) 29b. Signetuce end title of certifier 29c. License number 1/31/00 7)4372 30. Name end address of person who completed ceuse of deeth (Item 23a) (Type, Print) MAHMOUD 201-109 BackRiver Neck Rd Baltimore MD2/201 31. Dete filed (Month, Day, Year) 32. Registrar's Signeture State FEB 01 Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 3. Time of Death 2. Data of Death Day Month **Physician** Sudhir Desai 1200 4b. City, Town, or Location of Death 4c. County of Death 2000 /Medical 4a Facility Nama (If not institution, give street and number) Examiner of Baltimore H Under 24 Hrs. 8. Data of Bidh Hours Min. JAN 20, 1943 Huspital N/A 9. Birthplaca (State or Foreign Country) India If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Days ★□M 2□F Months 215-80-2025 57 Usual Rasidence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 ☐ No Baltimore Reisterstown 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 119 East Cherry Hill Road 21136 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 Ø No If Yes, Giva Year or Datas: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: specinAsian Indian by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highest grada completed) Elementary/Secondary (0-12) College (1-4or 5+) Self-employed Accountant 17. Father's Nama (First, Middla, Last) 18, Mother's Nama (First, Middle, Maiden Sumama) Be Himatlal Desai Hiralazmi Parikh 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 21136 19a. Informant's Name/Ratationship (Type, Print) 119 E. Cherry Hill Rd., Shobha Desai/wife Reisterstown, MD 20b. Place of Disposition (Nama of cemetary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State 1 Burial 2 Cramation 3 Removal from Stata 4 Donation 5 Other (Specify) Metro Crematory, Inc. 01/31/00 Baltimore, MD 21. Signature of Junaral Service Licensee 22. Nama and Address of Facility Cremation Society of Maryland, Inc. Thomas Gregor 299 Frederick Rd. Baltimore, MD 21228 23a. Part1. Enter the diseasa, or complications that caused tha death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximata Intarval Baltwee Consat and Death. Approximata Interval Batween Onsat and Death Immediata Causa (Final Anoxil Brain Ini diseasa or condition rasulting in death) Examiner Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Dua to (or as a consequence of) Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably Cunknown þ 24a. Was an autopsy performed? 24b. Wara autopsy findings available prior to completion of cause of death? Completed 20 No 1 Yas 2 No 25. Was casa referred to medical axaminar? Be 26. Place of Death (Check only one) To Hospital: Inpatient 2 ER/Outpatient 3 DOA 1 Yas 2 No Other: 4 Nursing Home 5 Residence 6 Othar (Specify) 27. Mannar of Death 28d. Describe how injury occurred 28b. Time of 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? Certification: 1 Natural 5 Pending invastigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be detarmined 3 ☐ Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 ☐ Homicida Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and mannar as stated. Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Data signed (Month, Day, Year) bons

State Registrar

Funeral

Director

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parmit. Pages 1 and 2 Department of Health a Important: If Hem 27 is any injury or other trei page.

Physician /Medical

Examiner

21215-0020

Baitimore, Maryland

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31. Data filed (Month, Day, Year)

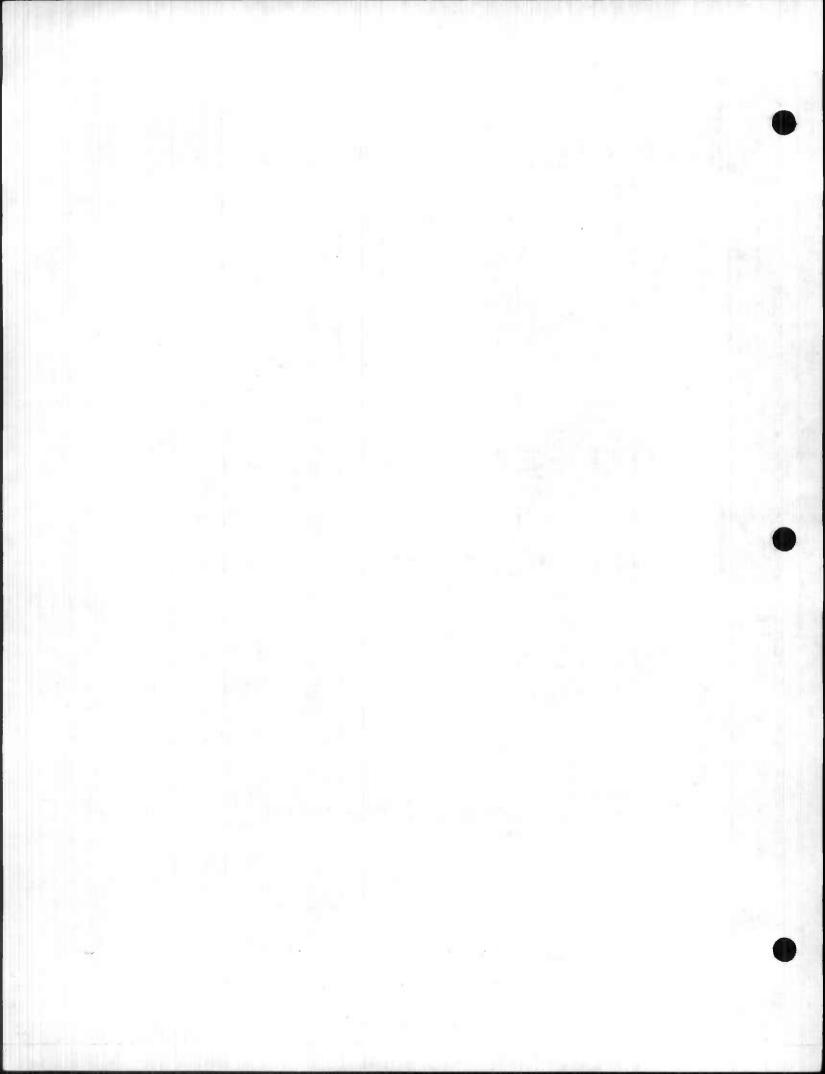
ms 2501 West Be redere Ade, Baitmore MD, 21215 32. Registrar's Signatura

30. Nama and addrass of person who completed causa of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Veer **Physician** 3:35 ARTHUR DEMARCO 2000 JAN 09 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BAUTIMORE N/A HOSPITAL If Under 24 Hrs. Hours Min. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 127-20-3139 Director NY Usual Residence of Decedent 10b. County must be notified at 10c. City. Town or Location 10d Insida City Limits MD Baltimore Baltimore 1 Yas 2 No Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 55 Wade Avenue Nems 23s 21228 USA Funeral 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 72 hours after 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Merried 2 Married 21215-0020 "netural", or 1 Yes 2√ No Specify: à white 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry ified within 7 Hygiene. other than "n Elementary/Secondary (0-12) College (1-4or 5+) . Pages 1 end 2 should be filed with ment of Health end Mental Hygien land; if flem 27 is marked other the jury or other traumatic event, the 11 unknown waiter restaurant Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be unknown Adeline DeMarco 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dominic DeMarco/cousin 5300 Washington St Bldg G324 Hollywood, FLA 33021 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State pemit. Page Department of Important: If eny Injury or once. 4 ☑ Donetion 5 ☐ Other (Specify) 21. Signature of Europeal Service Licensee Ronald S. Wade, Director 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Dece 1.00 Baltimore, MD 21201 23a. Phrt. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, spock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Causa (Final disease or condition resulting in death) /Medical ASPIRATION PNEUMONIA Examiner Examine Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? SEVERE COPD, PARKINSON DISEASE 1 Yes 2 No 3 Probably 4 Unknown of Vital Records, þ Completed BIPOLAR DISORDER 24a. Was an autopsy performed? 24b. Wera autopsy findings available prior to completion of cause of death? HIN 1 Yas 2 No 1 ☐ Yes 2 ☐ No Be 25. Was casa rafarred to medical 26. Place of Death (Check only one) Hospital: 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No Certification: To 27. Mannar of Death 28c. Injury at Work? 28d. Describe how injury occurred Division Attending Matural 5 Pending investigation death. 1 Yes 2 No 2 Accident efter death Director: 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide within 24 hours To the Funeral 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Morace, MD 30. Name and address of person who completed the person who completed t leted cause of death (Item 23a) (Type, Print) 900 CATON AVE, BALTIMORE, MD 21229

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State

Registrar

31. Data filed (Month, Day, Year)

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32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** GERALD S 4b. City, Town, or Location of Death GERALD S DUSZYNSKI, So.

4a Facility Name (If not institution, give street and humber) 26 7.00am 2000 · /Medical 4c. County of Death Examiner 7. Age (In yrs. last birthday) H Under 1 Yeer If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) (9.127 / 1.9.2/1) BALTIMORE CITY VETERAYS BALTMORE 5. Social Security Number Birthplace (Stete or Foreign Country) **Funeral** 10XM 2□ F Director 102-26-1871 65 New York Usual Rasidance of Decedan the Maryland 10a Slele 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or itema 23a or 28a-f ahow traumatic event, the Madical Examinar must be notified at 1 ☐ Yes 2 ☑ No Director Maryland Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? S • A •

14. Rece - American Indian,
Black, While, etc. Apt 103 Funeral 7987 Nolpark Court death 21061 Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 11. Maritel Status 72 hours after 1 Yes 2 No If Yes, Give Year or Datas: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: λq 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 2 should be filed within and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Owner / Operator Medical Equipment 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Stanley Duszynski Sally 0 Wielgasz 19a. Informant's Name/Ratationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) permit. Pages 1 and 2.
Department of Health at important: If Item 27 ie any Injury or other trau Donna Marie Duszynski (Wife) 7987 Nolpark Ct. Apt 103 Glen Burnie, MD 21061 20b. Placa of Disposition (Name of cematary, cramatory or other placa) 20c. Location - City or Town, State 20a. Mathod of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/30/2000 Chesapeake Cremation Center LLC Stevensville, MD 21. Signature of Funeral Service Licansee 22. Name and Address of Facility Singleton Funeral Home PA chael 1 Second Avenue S. W. Glen Burnie, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervat Between Onset and Death **Physician** /Medical Immadiata Causa (Final disease or condition resulting in death) METASTATIC CARCINOID CANCED Examiner Dua to (or as a consequenca of): Examiner CONGESTIVE HEART FAILURS ician and burial-transit Due to (or es e consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Disaasa or Injury physician a the burial Box 68760 99 Physician/Medical that initiated evants resulting in death) Last Due to (or as a consequence of): 98 ed by the attending I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? P.O. been signed by the should be detach 1 Yes 2 No 3 Probably 4 Unknown Division of Vitai Records. à 24b. Ware eutopsy findings available prior to complation of cause of death? 24a. Was an autopsy Completed has 1 Yes 2 No 1 Yes 2 No certificate funeral director, 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Be 26. Place of Death (Check only one) To Othar: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: After ! 1 Naturat 5 Pending death. 1 Yes 2 No Investigation 2 Accidant or Attend after death Director: 6 Could not be 3 ☐ Sulcide 28e. Ptaca of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 4 Homicida To the Hospital within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

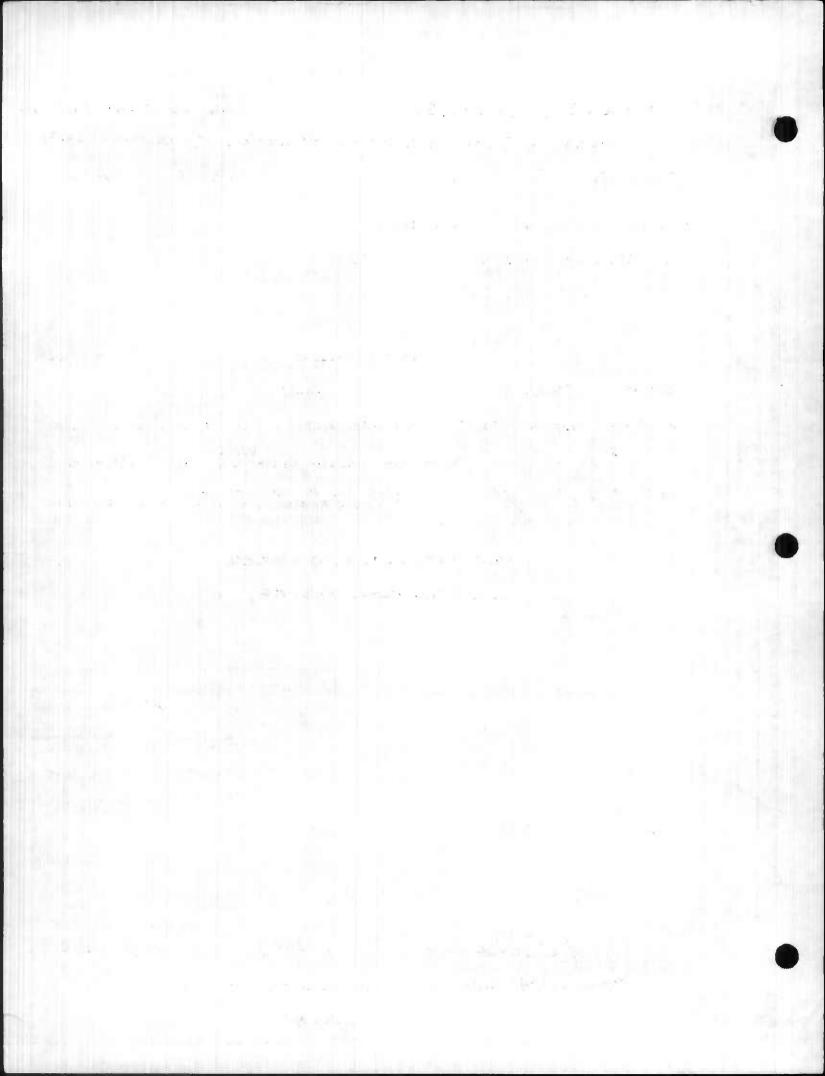
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifier Medical (Check only one) 29d. Date signed (Month, Dev. Year) 29b. Signeture end title of certifier 29c. License number JANUARY 26, 2000 MID 30. Nama and address of person who completed causa of death (Item 23a) (Type, Print) MARK SABA M.D. BALTIMORE VETERANS HOSPITAL 31. Date filed (Month, Day, Year)

DHMH 16 Rev 6/95

State Registrar

32. Registrar's Signature

2000



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene amend item 7 per fh 2/2/00 yg Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year **Physician** 10:25 PM neneva Douglas January 29 2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Baltimore Spital 6. Sex If Under 1 Yeer | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 M 2 F 218-28-6263 66 65 Yrs. Director -12 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore 1 Yes 2 No NA Director Ma 28a-f 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? a 23a or 608 Street 21205 Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 N No If Yes, Give' Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-iff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 20 No Specify: Specify: Black by 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry osewood Elementary/Secondary (0-12) College (1-4or 5+) th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be Duise Burgess Lohn 10n tgomen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) If them 27 is or other train N. Streeper Street Ma 6008 21205) ouglas 10 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 Burial 2 □ Cremation 3 □ Removel from State 2 -3-00 4 □ Donation 5 □ Other (Specify) Randallstown, Hd 21. Signature of Funeral Service Licenses 22. Neme end Address of Facility 21215 Ka lto ped Wabost 23s Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical tmmediate Cause (Final disease or condition resulting in death) Examiner Attending Physician: The lew requires that the death certificets be assected Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): physician the burle Box 68760. Physician/Medical for use signed by the a P.0. Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? 1 Yas 25 No 3 Probably 4 Unknown Division of Vital Records, by 24b. Were autopsy lindings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed certificata 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 8 26. Place of Death (Check only one) Hospitat: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) edicai Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural within 24 hours after death. To the Funeral Director: At completely filled in by the fu 1 Yes 2 No 2 Accident 6 Could not be 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 Homicide 8 Hospital 29a. Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29b. Signature and the of certifie 29c. License number 29d. Date signed (Month, Day, Year)

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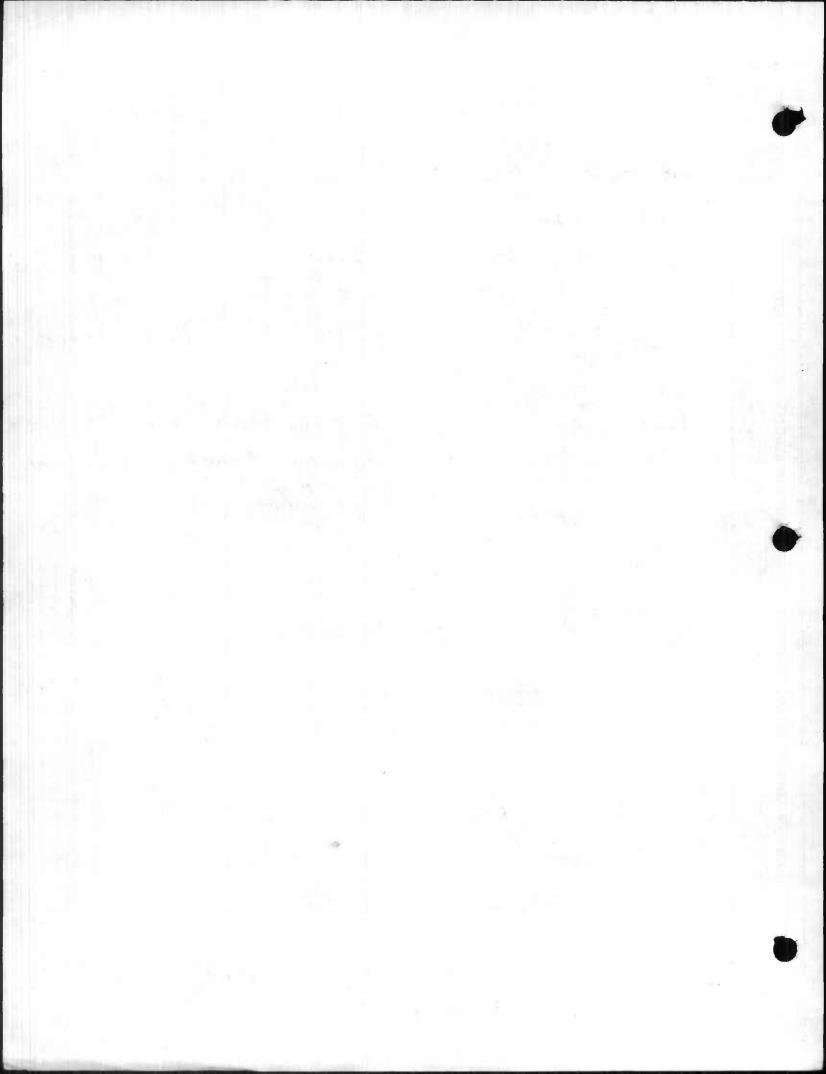
30. Name and address of person who co

32. Régistrar's Signature

ed cause of death (Item 23a) (Type, Print)

Sporks

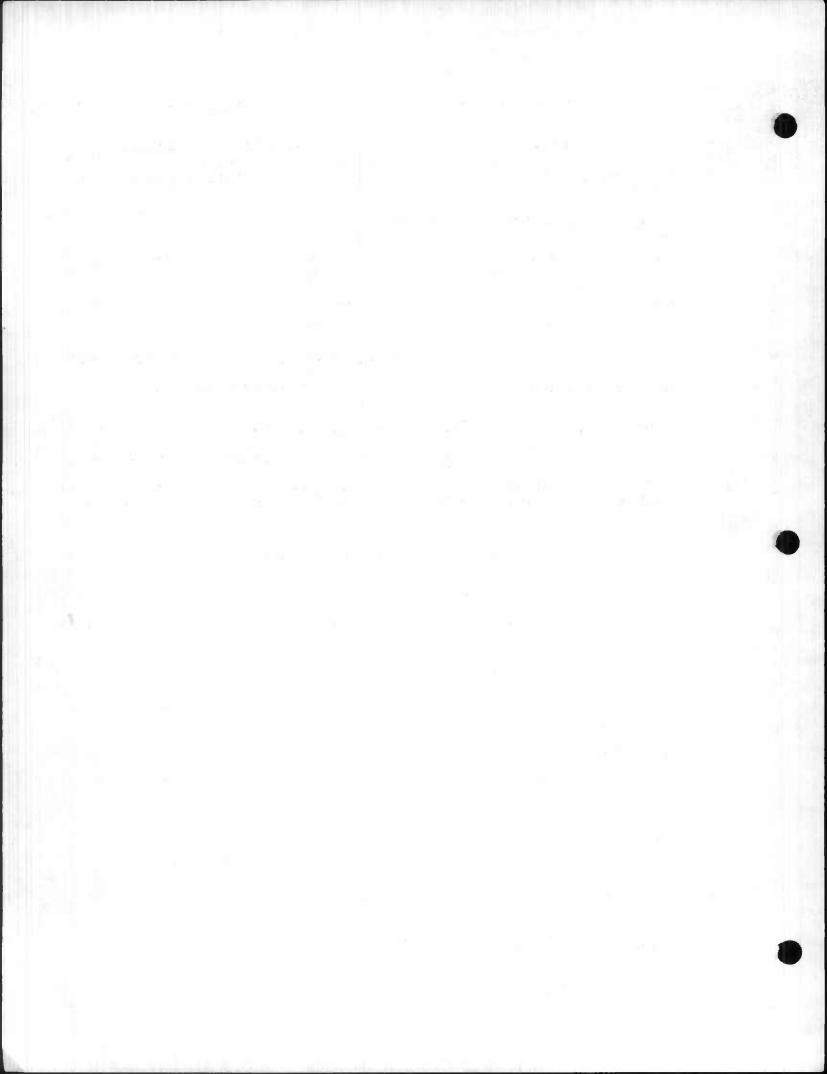
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| | | Certificate of Deat | | Reg. No. | 0 02472 |
|--|-------------------------|--|---------------------------------|---|--|
| Discola | | Decedent's Nama (First, Middle, Last) | 2. Date of | Death | 3. Time of Death |
| Physic /Medi | | Kenneth M. Danneman, Sr. | Jan. | 27-200 | 7:00 A.M |
| Exami | | | Town, or Location of De | ath 4c. County | of Death |
| | | 7514 Rabon Ave. Du | ndalk der 24 Hrs. 8, Date of | Balt | |
| Funeral Director | | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1. Age (In yrs. last birthday) | s Min. (Month, | Birth Dey, <i>Year)</i> 23,193 | 9. Birthplace (State or Foreign Country) 0 |
| land w | | 10a. State 10b. County 10c. City, Town or Location | | | 10d. Inside City Limits |
| with the Maryland a or 28a-f show the notified at | to | Md. Baltimore Dundalk | | | 1 Yas ZX No |
| or 28s | irec | 10e. Street and Number 10f. Zip Coda | | 10g. Citizen of V | Vhat Country? |
| th wi | al | 7514 Rabon Ave. 21222 | | U.S.A. | |
| 21215-0020 d within 72 hours after death piene. r than 'natural', or ferms 23 tre Medical Examiner must | by Funeral Director | 11. Marital Status 1 Never Married 2 Married 3 Wildowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, Give the Yes, Yes, Give the Yes, G | | | a - American Indian, k, Whita, atc. "White |
| 5-0 72 ho | ted | 15. Decedant's Education (Specify only highest grade completed) (Give kind of work done during m | and of condition | | siness/industry |
| Ehin il | Completed | (Specify only highest grade completed) (Give kind of work done during m life. DO NOT use retired) (Give kind of work done during m life. DO NOT use retired) | tost of working | | |
| | Co | 4 Maintance Forem | | | s Company |
| E Sigh | Be | | other's Neme (First, Midd | 2/10/20/20/20/20/20 | θ) |
| Maryiar d2 should be th and Ments 7 is marked traumatic ev | To | Gustav Danneman E1 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Num | lizabeth l | | 0.00 |
| Ma ind 2 s aith an 27 Is r | | | | | |
| s 1 and 1 Healt litem 2 | | Kenneth M. Danneman, Jr. 1234 Hilldale 20a. Method of Disposition 1 N Burial 2 Cremation 3 Removal from State | e Rd., Ba. | 20c. Location - | Md . 21237 City or Town, Stata |
| Ballimore, amil. Pages 1 ar apparament of Hea moortant: If item; ny injury or othe | | 4 □Donation 5 □Other (Specify) OakLAwn Cemetery | 1-31-00 | Balto | ., Md. |
| Department of the services | | 22. Name and Address of Fac Bradley-Asht 2134 Willow | on-Matthe | ews Fune | ral Home, Inc .,Md. 21222 |
| rificate be executed with the physician and as the burial-transit as the burial-transit as | Aedical Examiner | Immediate Cause (Final disease or condition resulting in death) a. Myclandial Infanction / Version of the consequence of its and the cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Implicated in fanction / Version of its and infanction / Version of its and its | | 7/11/19/1 | ~543 ~1043. |
| S, P.O. BOX es that the death cert igned by the attendin be detached for use | cian/ | a Hypertension | | | 722 42 |
| . 0 00 | ysi | Part tt. Other eignificant conditions contributing to death but not resulting in the underlying causa given in Part tt. | | | ntribute to the cause of death? |
| requires that the | by Pi | - Hyperlipidemia | | □ Yee 25 No | 3 Probably 4 Unknown |
| requir meen s hould | Completed by Physician/ | Obenty | 24a. W | as an autopsy informed? | 24b. Were eutopsy findings available prior to complation of causa of death? |
| The The page | No. | Asbestos Exposure | 1[| ☐ Yas 2 No | 1 ☐ Yes 2 ☐ No |
| Ilan: striffic artific actor, | Be | 25. Wes case referred to medical axaminer? | ece of Deeth (Check on | y one) | |
| Of VICAL MEC Physician: The law rthis certificate has b and director, page 2 s | 5 | 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ | Nursing Home 5 18 | esidence 6 DOth | ar (Specify) |
| ding P. After ti | | 27. Menner of Deeth 28a. Dete of Injury 28b. Time of 28c. Injury et Work? 2 | | e how injury occurr | ed |
| LIVISION OF VITA To the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director, | Medical Certification: | 2 Accident Investigation 3 Suicide 6 Could not be determined 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location | (Streat and Numb Fown, Stete) | er or Rural Route Number, |
| Hospita 24 hours Funeral ietely fille | dicai C | 29a. Certifier (Check only one) 1 Certifying Phyalcian: To the best of my knowledge, death occurred at the time, date and manner stated. | leath occurred at the tim | e, date and placa, i | and due to the cause(s) |
| To the To the | X | 29b. Signatura and title of certifier 29c. License numbe | ər | 29d. Data signed | (Month, Day, Year) |
| 1 3 | | Sharon Ollwork MD, MPH D474 | 412 | 1/28 | /00 |
| 10 | | 29b. Signatura and title of certifier 29c. License numbe 23c. Registrer's Signeture 31. Date filed (Month, Dey, Year) 32. Registrer's Signeture 33c. Registrer's Signeture | BALTIM | TRE. M. | 0 21224 |
| Sta | ite | 31. Date filed (Month, Dey, Year) 32. Registrer's Signeture | 1-11-11 | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | |
| Registr | | FEB 0 1 2000 per p sparks | | | |

DHMH 16 Ray 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death 1: 30 PM MARY DEFIBAUGH JANUARY 28 2000 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE HARBOR HOSPITAL CENTER N/A 7. Age (In yrs. last birthday) If Under 1 Yeer If Under 24 Hrs.

Works Deys Hours Min. 5. Social Security Number 6 Sax 8. Date of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) 1□ M 2ØF 212 42 0647 Yrs. 56 Jan. 29, 1943 Maryland Usual Residence of Decedent 10a State 10c City Town or Location 10b County 10d. Inside City Limits 11 Yes 2 No Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3721 St. Margaret Street 21225 U.S. 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Rece - American Indian. Bleck, White, etc. 1 ☐ Yes 2 ☑ No
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 Yes 2 No Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 11th 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Louise A. Schaffle William Koontz 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Baltimore, Maryland 21225 Gary Defibaugh / Husband 3721 St. Margaret Street 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, State 1 ⊠ Burial 2 ☐ Cremetion 3 ☐ Removel from State Gardens of Faith Cemetery 2/1/00 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Neme end Address of Fecility Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225 romeroush tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, in cause on each line. Approximate Intervel Between Onset and Deeth Immediate Cause (Finet disease or condition resulting in death) ARDS 10 DAYS Due to (or as a consequence of): SEPSIS 10 DAYS Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or es a consequence of): PNEUMONIA WEEKS that initiated events resulting in death) Last Due to (or es a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown COPD 24b. Were autopsy findings available prior to 24a. Wes an autopsy performed? TYPE DIABETES MELLITUS completion of cause of death? 1 Yes 2 No 1 Yes 2 No 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 1 Watural 5 Pending investigation

1 Yes 2 No

Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mennar as stated.

| Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

P 13471

281. Location (Street and Number or Rural Route Number, City or Town, Stete)

JANUARY

29d. Date signed (Month, Day, Year)

2000

Physician /Medical Examiner physician end the buriel-transit

Physician

/Medical

Examiner

Funeral

Director

or 28a-f show a notified at

ð

Berns 23s

'natural', or

filed within 7 Hygiene. Wher then "n

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Nem 27 is merked other any Injury or other traumatic event

72 hours after

Baltimore, Maryland 21215-0020

Director

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Box 68760, The law requires that the death certificate be 080 signed by the a d be detached f P.O. Records, of Vital this Certification: After Division or Attending

Physician/Medical Examiner þ To

Completed Be

s after de. • Funeral Dietely filled in Hospital To the Hosp within 24 hos To the Fune completely fi

DHMH 16 Rev 6/95

Registrar

Medical

31. Date filed (Month, Day, Year) FEB 0 1

2 Accident

3 ☐ Suicide

4 ☐ Homicide

(Check only one)

29b. Signeture and title of certifier

M Farel

6 ☐ Could not be

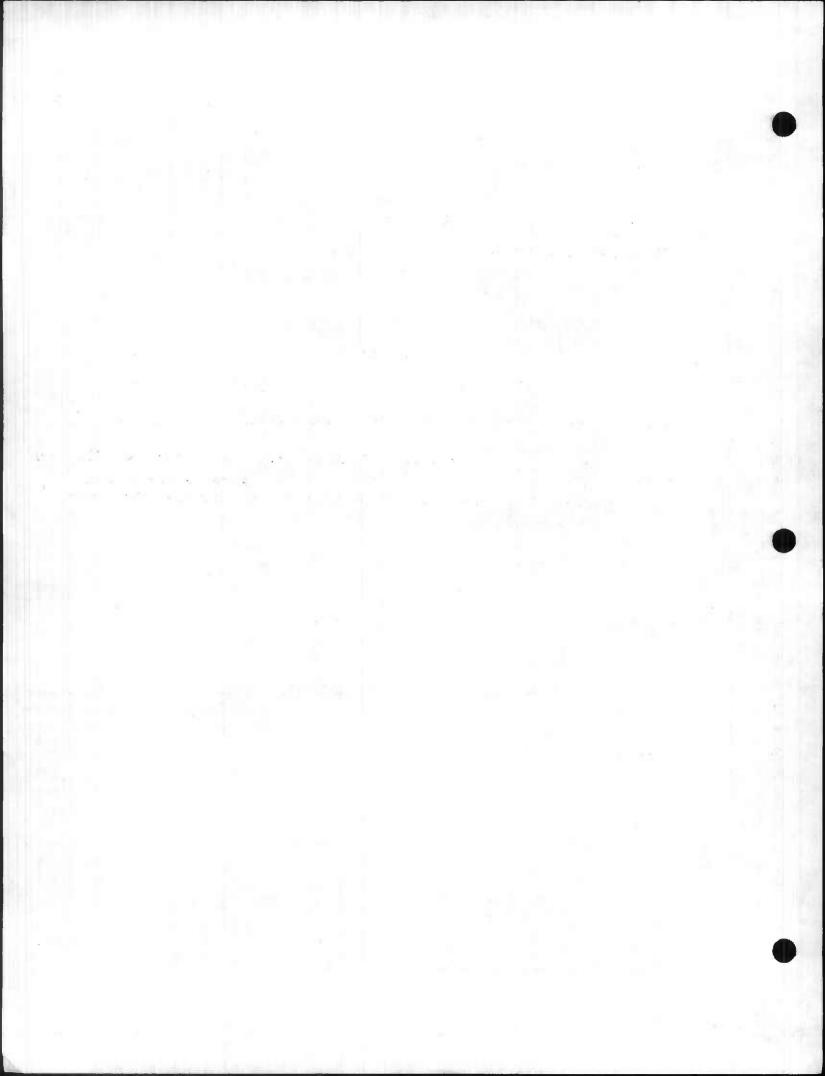
30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

MARINA FARAM, M.D., 3001 S HANOVER STREET, BALTIMORE, MD

32. Registrar's Signature

, PGY-1 INTERN

28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death January 29, 2000 **Physician** 4:55PM WILLIAM-M **JOSEPH** DRISCOLL /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Stella MAris Hospice Timonium If Under 24 Hrs 5. Social Security Number If Under 1 Year 8. Date of Birth (Month, Pay, Year) September 18, 1903 Massachusetts 7. Aga (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Months XXM 2□ F 579-05-6990 96 Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location r than "natural", or items 23s or 28s-f show the Medical Examiner must be nother at 10d. Inside City Limits 1 Yes 3 No Directo Maryland Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21093 2300 Dulaney Valley Road USA death 12. Was Decedenl Evar in U,S. Armed Forces? 1 ☐ Yes ÆÆANO If Yes, Give Yeer or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian. Black, White, etc. filed within 72 hours effer Hygiene. Ther then "natural", or ite WXNever Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 XX White Specify: Specify: by 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 5+ Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed wit. Department of Health and Mental hygiens Important: if item 27 is marked other the any injury or other treumatic event, that page. Fund Raiser Jesuit Missions 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle Maiden Sumame) Be William Joseph Driscoll Anna Mulholland 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rev. Pat Earl 5401 North Charles Street Baltimore, Maryland 21210 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 X Byrial 2 Cremetion 3 Removal from State Woodstock Cemetery 2/3/00 Woodstock Maryland nuntion 5 Other (Specify) ire of Funeral Service License 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc. 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complication ahock, or heart failure. List only one of that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximate Intervat Between Onset and Death **Physician** Stage Dementis /Medical Immediate Cause (Finat disease or condition resulting in death) Examine Due to (or as a consequence of): Examiner The law requires that the death certificate be assouted physician and the burief-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of): Box 68760, **Physician/Medical** that initiated events reaulting in death) Last Due to (or as a consequence of): 88 attending 080 0 P.O. Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given In Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 tinknown Division of Vital Records, by 24b. Were autopsy findings available prior to complation of causa of death? Completed 24a. Was an eutopsy performed? page 2 s 2 1 No 1 Yes 1 ☐ Yes 2 ☐ No or Attending Physician: Be 25. Was case referred to medicat examiner? 26. Placa of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Lo After this 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? edical Certification: 5 Pending investigation 1 Natural To the Hospital or Attending within 24 hours after death. To the Funeral Director: Afte completely filled in by the fun 1 TYes 2 No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At homa, farm, atreel, fectory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(a) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 143725 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) River Neck Road Baltimore MD31221 201-109 Back MAHMOUD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 01 seneva

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Registrar

Memosty finale

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene \(\) Certificate of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death **Physician** January 26, 2000 11:46 A.M. Lation of Death 9 /Medical 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, give street and number, Examiner 05 Center 15a Har 601 TMOST 9 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) **Funeral** Days 1⊠M 2□ F Months Hours 89 Director 208 01 8515 Sept. 10, 1910 Pennsylvania Usual Residence of Decedent the Manyland 10e State 10b County 10c, City, Town or Location 10d. Inside City Limits ahow filed within 72 hours after death with the Maryla Hygiens. Wher than "natural", or frame 23a or 28a-f show ant, the Medical Essevines mest be notified. 1 Yes 20 No Director Maryland Anne Arundel Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5335 Wasena Avenue 21225 U.S. Funeral 14. Race - American Indien, 11, Merital Status 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Bleck, White, atc. 1)∑Yes 2□No If Yes, Give Year or Dates: W.W. II 1 Never Married 2 Merried 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: à White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8th Factory Worker Lock Insulator Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) . Pages 1 and 2 should be file ment of Health and Mental Hi lamt: If Itam 27 Ia marked oth Jury or other traumatic avan (not available) Amelia John Druzgala 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wife 5335 Wasena Avenue Anne Druzgal Baltimore, Maryland 21225 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 □ Cremetion 3 □ Removel from State permit. Page Department Important: If any Injury or 1/31/00 Crownsville, Maryland Md. Veteran Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225 ramerousky ma bleations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. 23a. Pert1. Enter the disease shock, or heart failure. Approximete tntervel Between Onset and Death **Physician** Immedieta Cause (Final disease or condition resulting in death) /Medical Examiner Examiner physician and the burial-transit that the death certificate be assouted Sequentially list conditione, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Box 68760. oronar Physician/Medical 88 USe signed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 (Probably 4 Unknown Ď Records. The law requires 24b. Were sutopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed has egad 1 ☐ Yes 2 D No 1 Yes 2 No of Vital or Attanding Physician: 25. Wes case referred to medical examiner? 8 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 FER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No this funeral 28a. Date of Injury (Month, Day Year) 27 Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After Division 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No 24 hours after death.

Funeral Director: A 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical completely (Check only one) within 2 4 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 26,2000 January 30. Name and address of person who completed ed death (flors 23a) (Type, Print)

Registrar

State

Dr. Gerald Apollon

31. Date filed (Month, Day, Year)

FEB 0 1 2000

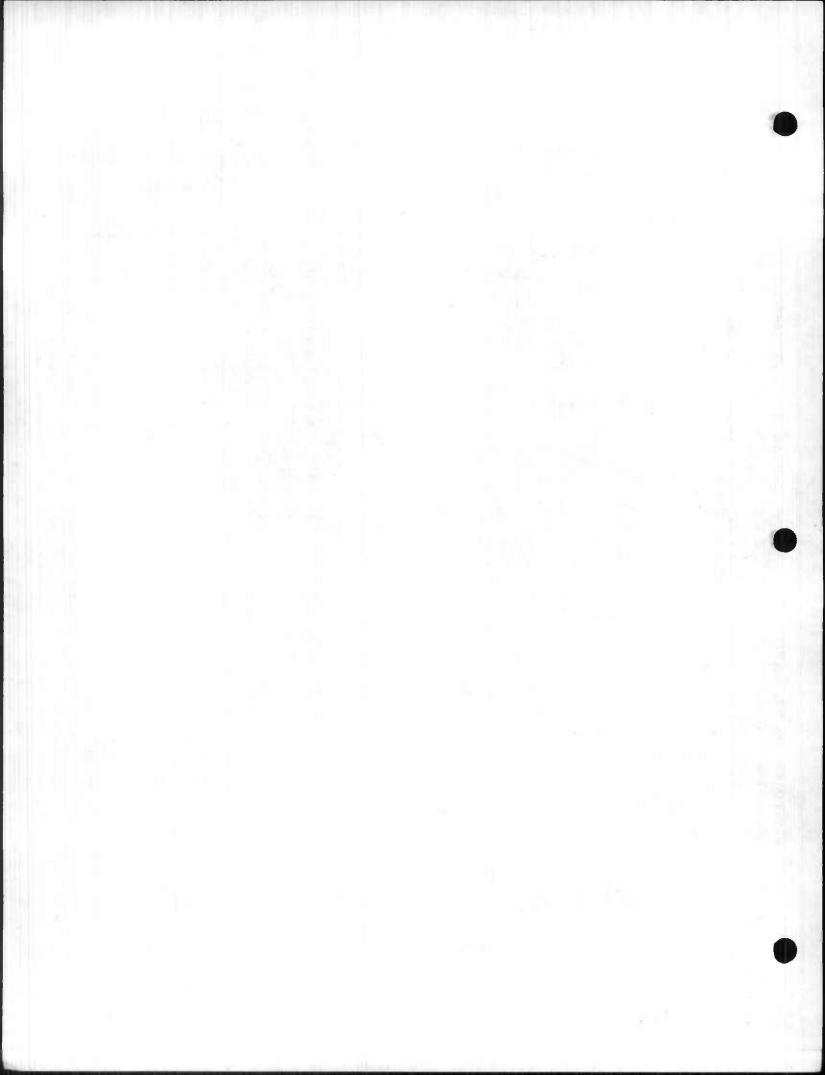
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Baltimore, Maryland 21225

3001 S. Hanover Street

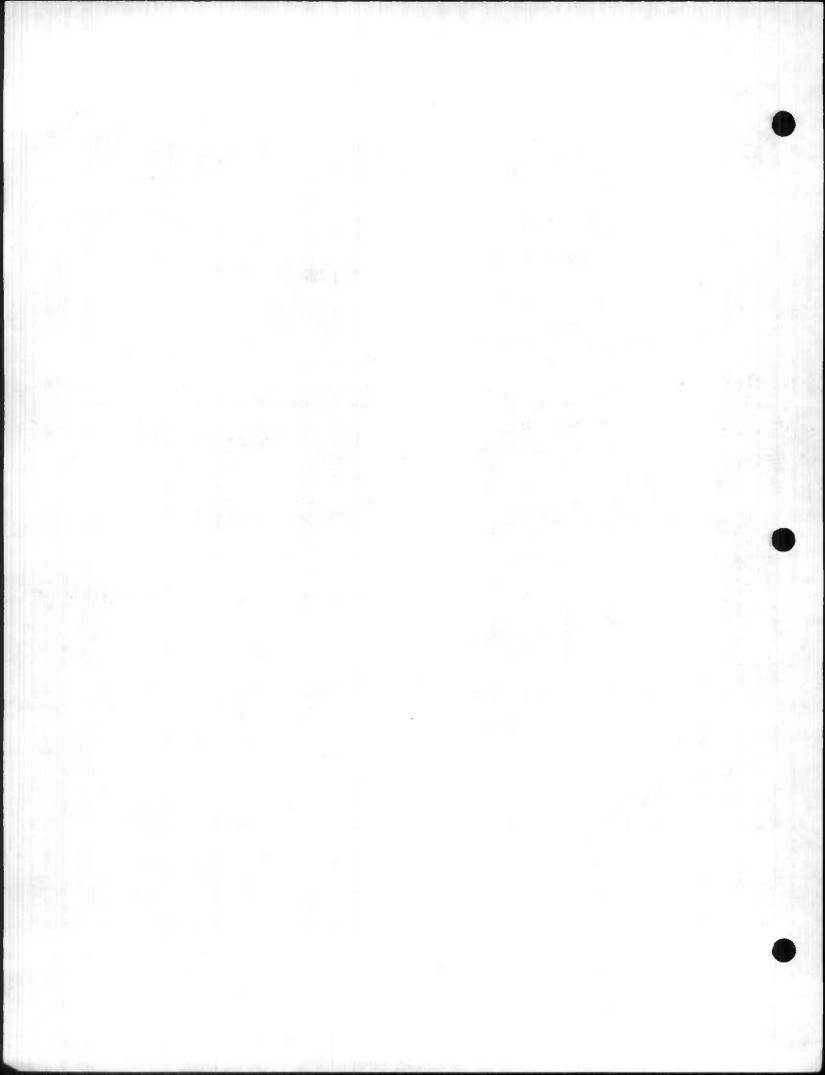
32. Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death 1. Decedant'a Nama (First, Middla, Last) 3. Time of Death Month Year **Physician** ALBERT. ELLIOTT 29, JANUARY 2000 9:40 pm /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PASADENA ANNE ARUNDEL OAKLODGE SENIOR HOME If Under 1 Year | If Under 24 Hrs 5. Social Security Number 7. Age (In yrs. last birthday) Birthplaca (Stata or Foreign Country) 8. Data of Birth (Month, Day, Year) **Funeral** Days Hours Months 110 M 2□ F Yrs 85 Director 216-03-8658 SEPT. 26, 1914 MARYLAND 10a State 10b. County 10c. City. Town or Location 10d. fnside City Limits 28a-f show 1 ☐ Yes 2 No Director MARYLAND ANNE ARUNDEL LINTHICUM HEIGHTS 10e Street and Number 10f. Zip Code 10g. Citizan of What Country? b munt be "natural", or harms 23s 902 LYNVUE ROAD 21090 Funeral U.S.A 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - Amarican Indian, 11. Marital Status Black, White, etc. after 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 🗓 No Specify: If Yas, Give Year or Datas: Specify: à 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupetion (Give kind of work dona during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) Collega (1-4or 5+) 12 ENGINEER STEEL MILL 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Sumama) pamit. Papes 1 and 2 should be file Department of Health and Mental Hy Important: If Iham 27 is marked oth any Injury or other traumatic event Be ALBERT P. ELLIOTT LAURA G. TAYLOR 19b. Meiling Addrass (Street end Number or Rural Routa Number, City or Town, State, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) MARIE R. ELLIOTT- WIFE 902 LYNVUE ROAD, LINTHICUM HEIGHTS, MARYLAND 21090 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State Date 1 Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 2-2-4 ☐ Donation 5 ☐ Othar (Specify) GLEN HAVEN MEMORIAL PARK 2000 GLEN BURNIE, MARYLAND 22. Neme end Address of Fecility 21. Signature of Puneral Service Licensee SINGLETON FUNERAL HOME, PA. SECOND AVE., SW., GLEN BURNIE, MARYLAND 21061 the disease, or complications that caused the daath. Do not entar tha mode of dying, such as cardiac or respiratory arrest, and failure. List only one cause on each line. Approximata Intervel Between Onset and Death **Physician** /Medical Immediata Ceuse (Final · Cerebro vasular accident diseasa or condition rasulting in death) **Examiner** Due to (or as a consequance of): Examiner physician and the burial-transit be axacuted Sequentially list conditions, if any, laading to immadiata causa. Entar Underlying Cause (Disease or Injury that initialed evants resulting in death) Last Due to (or as a consequenca of): Box 68760. Physician/Medical Due to (or as a consequance of): for use as Part ff. Other algorificant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? o the 3 1 Yan 2010 3 Probably 4 □ Unknown ۵. artery bypass Burgery signed I Records, þ 24b. Wera autopsy findings available prior to Completed 24e. Was an autopsy peed performed? completion of cause of death? The law page 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital or Attending Physician: director. 25. Was casa rafarrad to medical Be 26. Place of Deeth (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 Yas 2 No this funeral 28a. Data of Injury (Month, Day Year) 27. Menger of Death 28d. Describe how Injury occurred 28b. Tima of 28c. Injury at Work? After 1 Natural Injury 5 Pending after death. Director: Aft 1 Yas 2 No investigation 2 Accidant 6 Could not be datarmined 3 ☐ Suicida 28a. Placa of Injury - At homa, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Steta) 4 Homicida To the Hospital or within 24 hours aft To the Funeral Di completely filled in 29a. Certifier 1 Certifying Phyaician: To the best of my knowledge, deeth occurred at the tima, data and place, end dua to the causa(s) and mannar as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Data signed (Month, Day, Year) deles D23624 gan. 31. 2000 30. Nema and addrass of person who completed causa of death (Item 23a) (Type, Print) GlenBurnie 1600 S mD 21061 # 306 Crain Hwy 31. Data filed (Month, Day, Year) 32. Registra/s Signatura State 1 2000 Darks Denew FEB 0 Registrar BBBBB 0.0004

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Month Day Year **Physician** PHILLIP 26 DWIGHT **EDWARDS** SR. JAN 2000 unknown /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5620 ALHAMBRA AVENUE BALTIMORE CITY N/A If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) **Funeral** Days Months Hours 1⊠M 2□ F Yrs 58 Director 217-34-4395 02-12-41 North Carolina Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Nome 23a or 28a-f ahow the Medical Examinar must be notified at 1⊠Yas 2□No Director Maryland N/A Baltimore 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 5620 Alhambra Avenue death 21212 Funeral U.S.A.

14. Race - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) Black, Whita, alc. filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yas, Giva Year or Datas: Phillip Dwight Edwards Baltimore, Maryland 21215-0020 1 Never Married 2€ Married natural, or 1 ☐ Yes 2 ☑ No Specify: Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if itam 27 is marked other than 'any Injury or other traumstic avant, me he any Injury or other traumstic avant, me he any once. Elementary/Secondary (0-12) College (1-4or 5+) 12th Grade N/A Bus Driver MTA 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle Maiden Sumama) Be Paul Edwards, Sr. Maudie Madden Edwards 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Agnes Edwards/WIfe 5620 Alhambra Avenue Baltimore, Maryland 21212 20a. Mathod of Disposition 20b. Place of Disposition (Nama of Data 20c. Location - City or Town, Stata cematary, cramatory or other place) 1€ Burial 2 □ Cremetion 3 □Removal from Stala 4 □ Donation 5 □ Other (Specify) King Memorial Park 01-29 Owings Mills, Maryland 21. Signature of Funeral Service Licens 22. Neme end Address of Facility William C. Brown Community Funeral Home, P.A. 1206 W. North Avenue Baltimore, Maryland 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** Immediata Causa (Final diseasa or condition resulting in death) Cenkemia /Medical 1mphs month Examiner Examiner **burial-transit** The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of): physician s the buria Physician/Medical Dua to (or as a consequence of): -200 signed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 20 No 3 Probably 4 Unknown by 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed Pas page 2 1 Yes 1 □ Yas 2 □ No 25. Was case referred to medical axaminer? Be 26. Place of Death (Check only one)

certificata this Aftar

Sr

Box 68760, or Attanding Physician: funaral filled in by

P.O. Records, Division of Vitai Hospital or Attanding 124 hours after death.
 Funeral Director: Aft completely within 2. To the F \$

2

Certification:

edical

1□ Yes 201Ne

5 Pending

2000

investigation

6 Could not be determined

27. Manner of Death

10 Natural

2 Accident

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

(Check only one)

29b. Signature and alth of contiller

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Registrar

State

Cartifying Physician: To the best of my knowledge, death occurred at tha time, date and place, and due to the cause(s) and manner as stated.

| Manual Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

000

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

30 Name and address of person who completed cause of death (Item 23a) (Type, Print), 6565 Colano MO rurles 44 31. Data filed (Month, Day, Year)

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify)

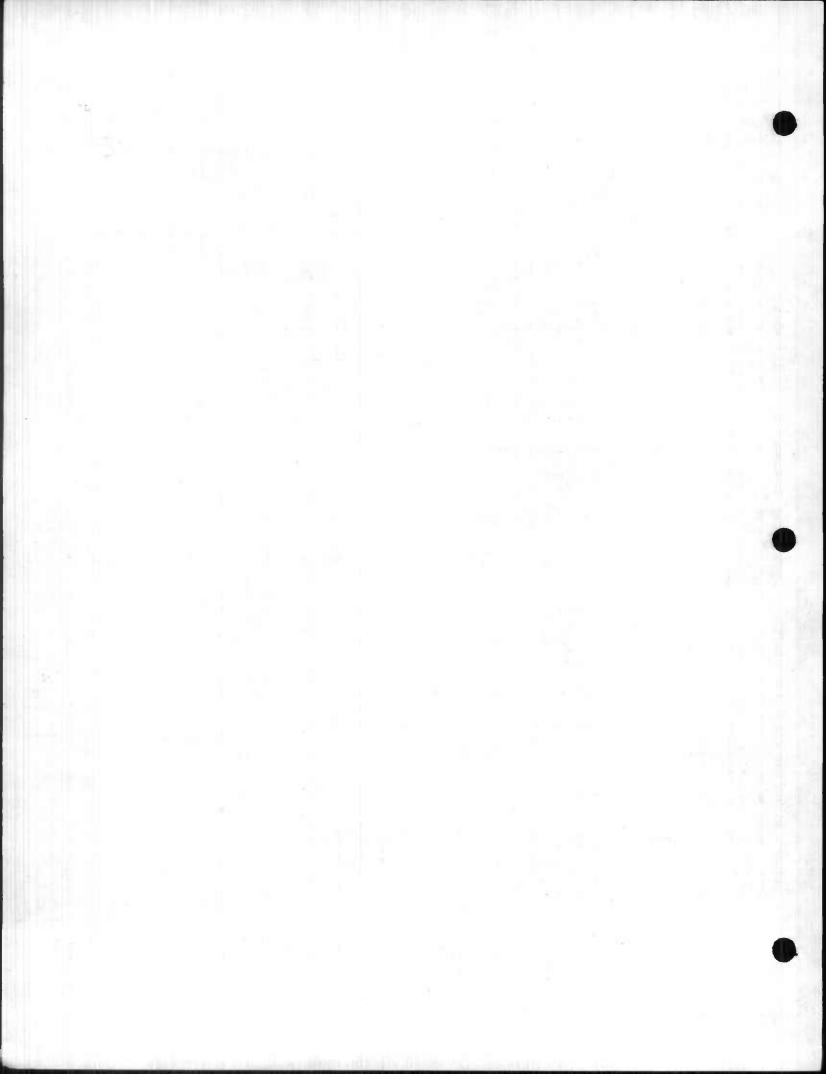
28b. Tima of

32. Registrar's Signet

28a. Data of Injury (Month, Day Year)

Other: 4 Nursing Homa 5 Residence 6 Other (Specify)

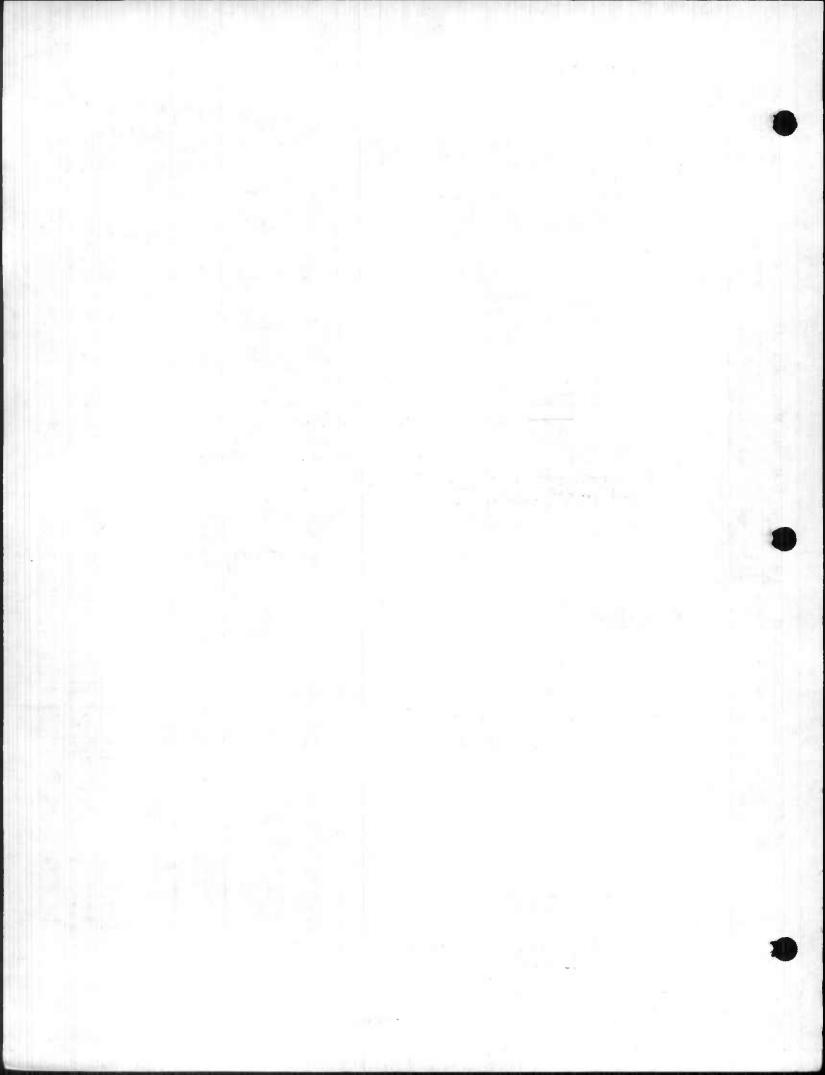
28d. Describe how injury occurred



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMEND#19A PER F.H. G781 3-8-2000 JAB Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** ERYPSOLE ATRICIA 9 NUA24 25 2000 /Medical 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death c. County of Death Examiner Ratt more Hunder 24 Hrs. 8. Date of Birth (Month, Day, Year)
15 1939 HOPKINS Johns 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under Birthplace (State or Foreign Country) **Funeral** Days Months 1 M XIX F 173-32-7462 60 PA Sept. 15, Director Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location raif, or items 23a or 28a-f ahow Examiner must be notified at 10d. Inside City Limits PA York York 1 ☐ Yes 20X No Director 10e Street and Number 10g. Citizen of What Country? 10f. Zio Code 303 Cedar Village Drive 17402 United States Funeral death 14. Race - American Indian, Black, Whita, etc. 11 Marital Status 12. Was Decedent Evar in U.S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after c. Department of Health and Mental Hygiene. Important: If filem 27 is marked other than "natural". ce in any injury or other traumatic event Uhk. 1 Yes 2 No MX Never Marriad 2 Married 1 Yes 20tho Specify: Specify: p White 3 ☐ Widowed 4 ☐ Divorced Yeer or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Mail Sorter 12 Postal Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be R. Richard Ebersole Ruth P. Hutton 19a. Informant's Neme/Relationship (Type, Print) 19b. Meiting Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Randy Ebersole / Nephew 303 Cedar Village Drive, York PA 17402 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☑ Removal from State Susquehanna Memorial Gardens Z/1/2000 4 ☐ Donetion 5 ☐ Other (Specify) York PA 21. Signature of Euneral Service Licensee Victor P. Doda, Jr. Charles L. Stevens Funeral Home, Inc. 1501 Fast Fort Avenue, Baltimore Maryland 21230 23a. Part1. Enter the disease, or complications that caused he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final CHRONIC REJECTION RIGHT LUNG 6 months disease or condition resulting in death) Examiner Due to (or as a consequence of) Examine ician and burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Łast Due to (or es a consequence of): physician the burial P.O. Box 68760, Physician/Medical Due to (or as a consequence of): Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Houte on Chronic Renal 1 Yes 2 No 3 Probably 4 Unknown FAILURS Records. þ 24b. Were autopsy findings available prior to completion of cause of death? SEVERE Chronic Obstructive Pulmonary 24a. Was an autopsy performed? Completed page 2 s 1 Yes 1 Yes 2 No Division of Vital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1□ Yes 20 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1. Inpatient 2 □ ER/Outpatient 3 □ DOA this funeral 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? After Naturat 5 Pending Investigation e Hospital or Attending 24 hours after death. e Funeral Director: Aft 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Hom/cide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 24 ho To the Fune completely fi (Check only one) \$ 29b. Signature and title of certifian 29c. License number 29d. Date signed (Month, Day, Year) RES-000 II MID. E. Was JANUARY 25 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 NORTH WOLFE STREET BOLTIMCRE MARYLOND 2128/ RICHARD E. WATERS I 31. Date filed (Month, Day, Year) 32. Registrar's Signeture State FEB 0 1 2000

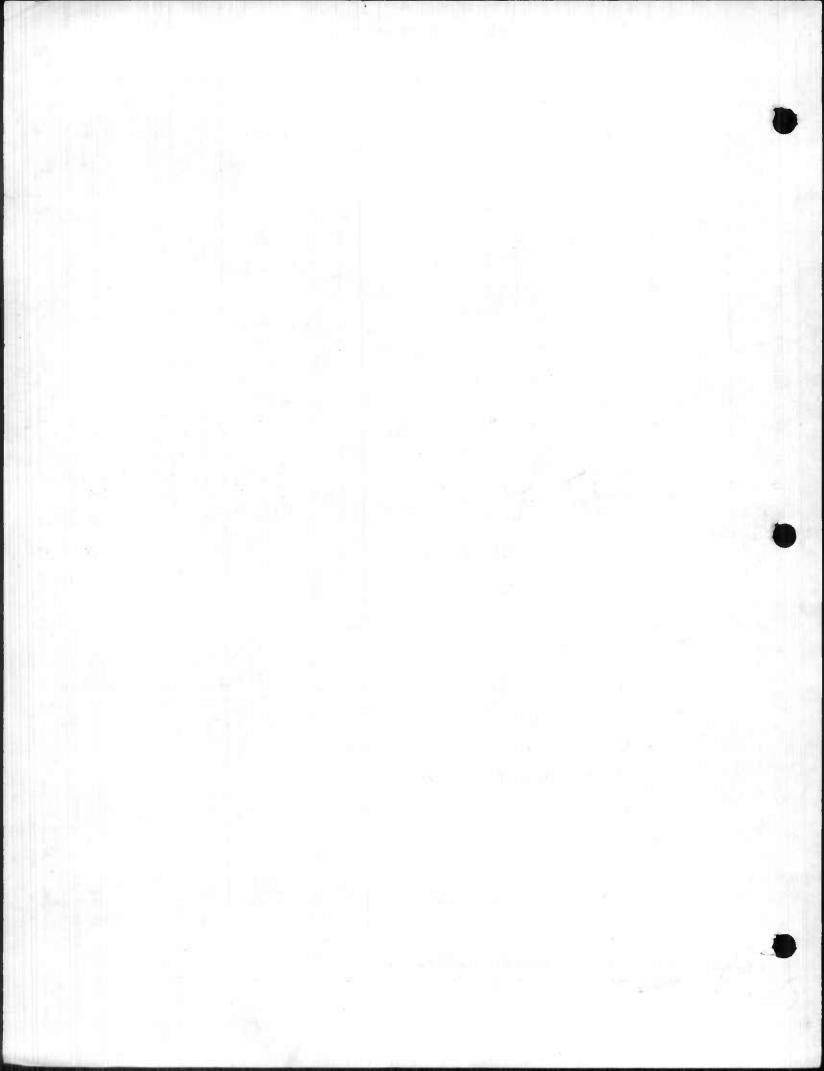
Registrar



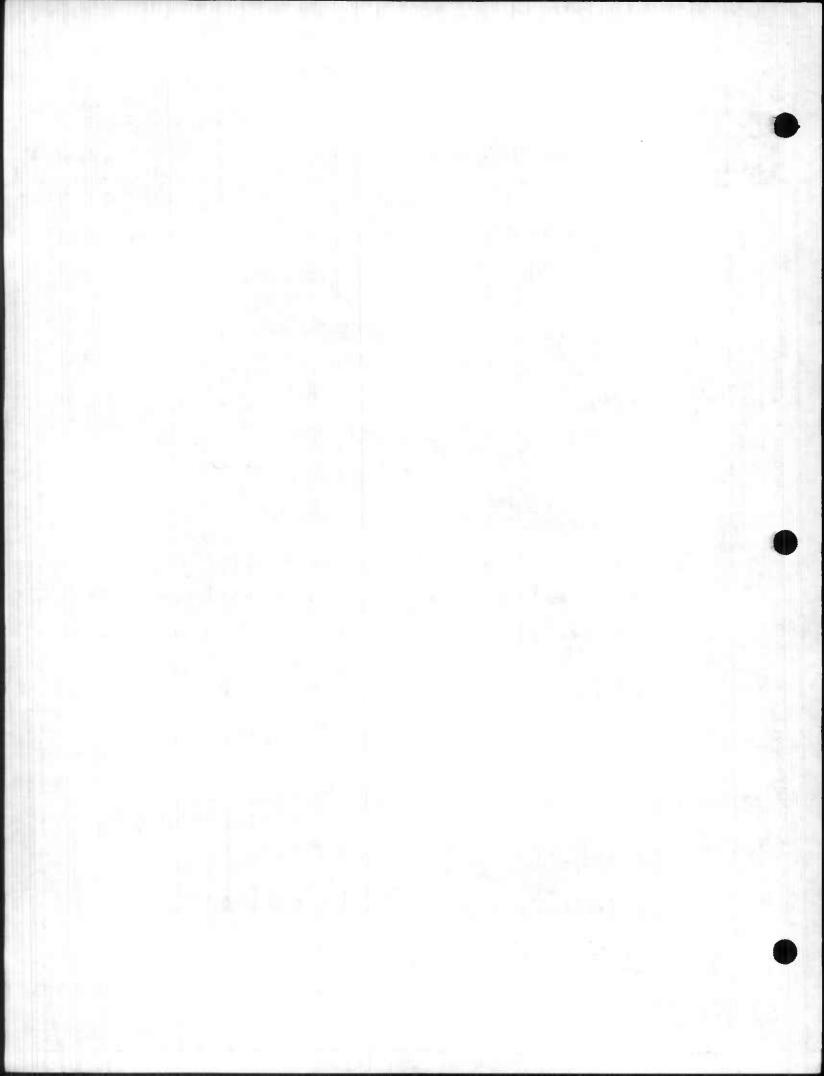
| Dhucinian | | ne (First, Middle | | | | | | | 2. Date of De _ Month | | Year | 3. Time of Death |
|--|--|--|---|--|--|--|---------------------------------|---|---|---|--|--|
| Physician /Medical | TAGT. | yn Gert | | ırbay | | | | | Januar | | | 8:20a.m. |
| Examiner | 4a Fecility Name (| | give street and not sing Cent | | | | | b. City, Town, or Baltimo | | 1 4c. Coun n/a | ty of Death | h |
| Funeral Director | 5. Social Security I 220 – 22 – 2 | | 6. Sex 1 ☐ M 27 F | 7. Age (In yr 85 | s. last birthday Yrs. | Months | 1 Year Days | If Under 24 Hrs Houra Min. | 8. Date of Bird (Month Da Sept.8, | y. Y974 | 9. Birth | hplace (State or Forei united ryland |
| 1 | Usual Residence of | of Decedent 10b. County | | 10c. (| City, Town or L | ocation | | | | | | 10d. Inside City Limi |
| ms 23s or 28s-f show rmsst be notined at | Maryland | Baltin | nore | | | | ver1 | .ea | | | | 1 Yes 2 |
| or 28=4 be notified | 10e. Street and Nu | | | | 8 6 | 10f. Zip | Code | | | 10g. Citizen of | Whet Cou | untry? |
| 23 E | 53. | 1 Old Ho | ome Road | | | | | 21206 | | United | | |
| 2 E | | rried 2 Marrie | 12. Was De Armed I ed 1 1 Yes If Yes, O Year or | cedent Ever in Forces? 247 No Sive Dates: | U,S. 13. | . Was Decede If Yes, speci | | ispanic Origin? (S an, Mexican, Puerl Specify: | pecify Yea or No o Rican, etc.) | | ace - Amer ack, White ify: Wh: | |
| ygiene. Ner than "natural", c nt, me Medical East Completed by | (Spe | 15. Decedent | a Education | 0 | 16a. Deci | edent's Usua e kind of worl | Occupa | ation during most of world | rking | 16b. Kind of I | Business/I | industry |
| iene. De Ken | Elementary/Sec | | 1 | (1-4or 5+) | | Wrapp | |) | | Pantry | Pric | de |
| tal Hygie d other event, B | 17. Father's Name | | .ast) | | 11000 | птарр | | 18. Mother's Nar | ne (First, Middle, | | | 40 |
| f Heelin and Mental Hyginem 27 is marked other other treumstic event, | | | Charle: | s Wils | on | | | Ber | tha | Turn | er | |
| and N | 19a. Informant's N | lame/Relationsh | iip (Type, Print) | | 19b. Mai | ling Address | (Street | and Number or Ru | ural Route Numbe | er, City or Tow | n, State, Z | ip Code) |
| Heelth em 27 other tr | | | chell (Da | | | Old H | ome | Road Ove | | | | |
| n O n | | Cremation | 3 Removal from | n State | Place of Disp cemetery, cri | ematory or of | her plac | (a) | Date I | 20c. Location | | , Maryland |
| ortant: Injury | 4 Donation | 5 Other (Sp | | Ба | | | | | | | | |
| Department draportant: If amy injury or price. | 1 | -10 | V 000 | Me Me | 2333 g | 700 T 41 | L | y Rd. Ra | ing Bye | rs Fune | ral l | Directors |
| /Medical | Immediate Cause | (Final | | | | | | g, such as cardia | or respiratory a | rrest, | | Approximate Interval Between Onset and Death |
| Medical xaminer sthe purish transit set the purish fransit set the purish transit set the p | Cause (Disease of that initiated event resulting in death) | onditiona, mmediate lerlying t hijury | | hydr Due to Due to | | equence of): equence of): | | g, such as cardia | c or respiratory as | rest, | | Interval Between Onset and Death |
| physician and ss the bunial-transit and edical Examiner | disease or conditive resulting in death) Sequentially list or if any, leading to it cause. Enter Und Cause (Disease or that initiated event resulting in death) | onditiona, mmediate lerlying rinjury ts Last | a. do b. Le c. Ac d | hydra Due to Due to | atting (or as a conse (or as a conse (or as a conse | equence of): Autipaper of the sequence of the |) | | 23b. Dld | lobacco uee c | | Interval Between Onset and Death 4 days 4 days 8 days to the cause of dea |
| physician and ss the bunial-transit and edical Examiner | disease or conditive resulting in death) Sequentially list or if any, leading to it cause. Enter Und Cause (Disease or that initiated event resulting in death) | onditiona, mmediate lerlying rinjury ts Last | a. do b. Le c. Ac d | hydra Due to Due to | atting (or as a conse (or as a conse (or as a conse | equence of): Autipaper of the sequence of the |) | | 23b. Dld | | | Interval Between Onset and Death 4 days 4 days 8 days to the cause of dea |
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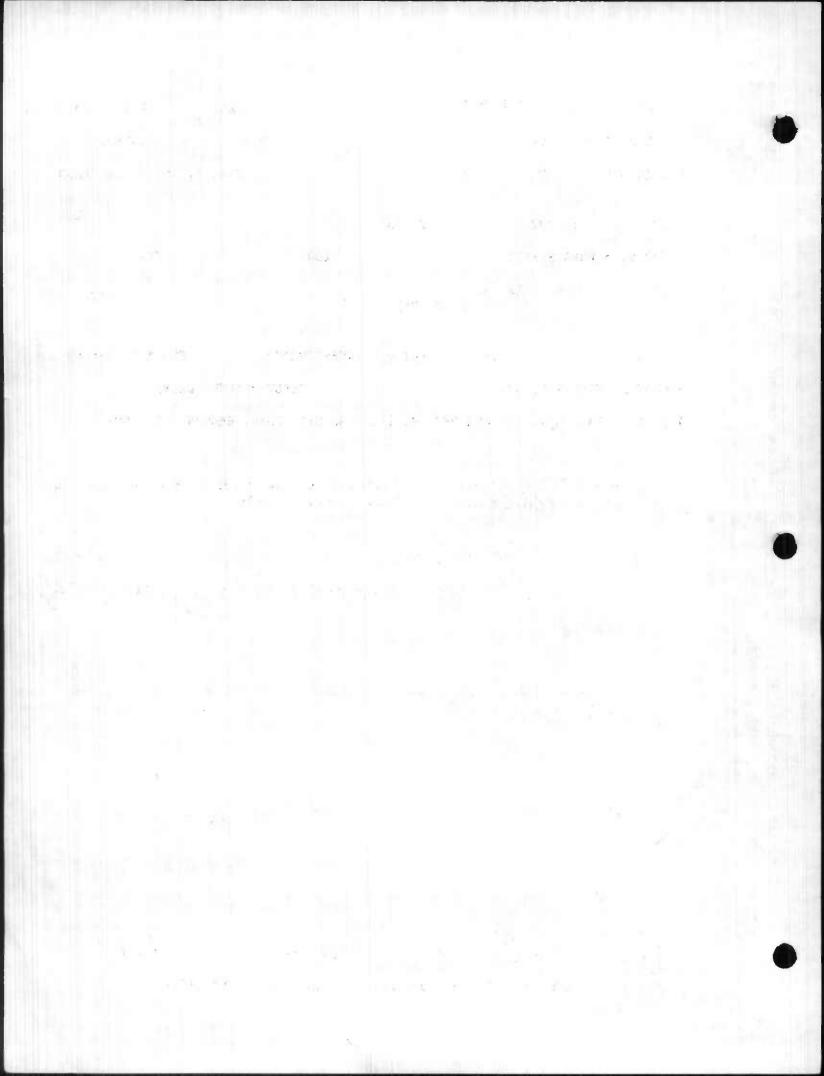


| 55 | Certificate of Death | Reg. No. | 02400 |
|--|--|--|--|
| Physician /Medical | 1. Decedent's Name (First, Middle, Last) Boatrice M. Farrington | 2. Dete of Deeth Month Day CONUCY 2 1 200 To County of Death 4c. County of | |
| Examiner | Anne Arundel Medical Center Annap | olis Anne A | AND THE RESERVE OF THE PARTY OF |
| Funeral Director | 5. Social Security Number 6. Sex 510-26-4677 1 M 20 F 7. Age (In yrs. last birthday) Wonths Days Hours Usuel Residence of Decedent | Min. (Month, Dey, Year) | 9. Birthplece (State or Foreign Country) Kan395 |
| death with the Maryland time 23s or 28s-f show counted at mounted at the profession of the counted at the profession of the counter of the co | 10a. State 10b. County 10c. City, Town or Location Anne Arunde A | 3 - 19-111 | 10d. Insida City Limits 1 ☑ Yes 2 ☐ No |
| ath with the Maryla 23a or 28a-f sho lat be noutfied it rai Director | 10e. Street and Number 10f. Zip Code 2 1403 | 10g. Citizen of Wh | nat Country? |
| 를 보고 교 | 11. Mantal-Status 12. Was Decedent Ever in U,S. Armed Forces? 1 □ Never Married 2 Married 12. Was Decedent Ever in U,S. Armed Forces? 1 □ Yes 2 No It Yes, Give | | - American Indian, White, etc. |
| "natural" rulical Ex | 15 Decedent's Education 16e Decedent's Usual Occupation | f working 16b. Kind of Busi | UNITE iness/Industry |
| or then | Elementary/Secondery (0-12) Collega (1-4or 5+) Scam5+rc55 | Self-er | |
| should be find Mental H marked off imatic avar | 17. Father's Name (First, Middla, Last) 18. Mother's Rose | Neme (First, Middle, Maiden Sumema, |) |
| d 2 should be file th end Mental Hy 7 is marked oth traumatic svan To Be | 19a. Informant's Name/Refationship (Type, Print) 19b. Meiling Address (Street end Number of Street) 2100 Control of Street end Number | .Λ | |
| 8 = 5 | Robert 6. Gensler 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from Stete 20b. Place of Disposition (Name of cemetery, cremetory or other place) | Dete 20c. Location - C | 463 ity or Town, Stele |
| permit. Pa Departmen Important: any injury pace. | 4 Donation 5 Other (Specify) Hintonic 61ft Foundation 21. Signature of Fundation Service Contest 22. Name and Address of Facility Anatomic 61ft | Foundation | MD |
| | 23a Part I Faller the dishese, or complications that caused the death. Do not enter the mode of dying, such as ce shock a heart failure. List only one cause on each line. | Church MD 20 profiles or raspiratory arrest, | Approximete Interval Between |
| Physician /Medical Examiner | Immediate Ceuse (Finel diseases or condition resulting in deeth) a. HYPOXEMIA | | Onset and Deeth 30 MINUTES |
| p ju ju | CHRONIC OBSTRUCTIVE PULM | NOWARY DISEASE | 5 YEARS |
| be executed sician and burial-transit | Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disaase or injury c. TYPE TWO DIABETES | | 5 YEARS |
| the death certificate by the attending physietached for use as the Physician/Medica | Due to (or as a consequence of): d. DEST_ | | 10 YEARS |
| ires that the death certisioned by the attending does detached for use a d by Physician/M | Pert II. Other significant conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. | | ribute to the cause of death? 3 Probably 4 Wunknown |
| requi | | 24e. Wes an eutopsy performed? | 24b. Were autopsy findings eveilable prior to completion of cause of death? |
| : The law requires to cate has been signer, page 2 should be Completed by | | 1□ Yas 2 No | 1 Yes 2 No |
| Physician: The this certificate ral director, pagers TO Be Co | examiner? | t Death (Chack only one) ing Home 5□ Residence 6 □Othar | (Specify) |
| £ 4 5 5 | 27. Mannar of Death 1. Natural 5 Panding (Month, Dey Year) 2 Accidant investigation 28b. Tima of Injury 28b. Tima of Injury 4 Work? 1 Yes 2 No. | 28d. Dascriba how injury occurre | |
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| n 24 hours n 24 hours pletely fill edical | 29a. Certifier (Check only one) 12 Certifying Physician: To the best of my knowledga, deeth occurred at the tima, deta end process of my knowledga, deeth occurred at the tima, deta end process of my knowledga, deeth occurred at the tima, deta end process of my knowledga, deeth occurred at the tima, deta end process of my knowledga, deeth occurred at the tima, deta end process of my knowledga, deeth occurred at the tima, deta end process of my knowledga, deeth occurred at the tima, deta end process of my knowledga, deeth occurred at the tima, deta end process of my knowledga, deeth occurred at the tima, deta end process of my knowledga, deeth occurred at the tima, deta end process of my knowledga, deeth occurred at the tima, deta end process of my knowledga, deeth occurred at the tima, deta end process of my knowledga, deeth occurred at the tima, deta end process of my knowledga, deeth occurred at the tima, deta end process of my knowledga. | place, end due to the cause(s) end man occurred at tha tima, date and place, ar | ner as stated. nd dua to tha cause(s) |
| To the within To the comp | 29b. Signature and title of certifier 29c. License number | 29d. Date signed FEBRUA LAND ROAD ANNAR | (Month, Day, Year) |
| 2 | Machine / Limitavia - 0 337. | | TICY LOUD |



Please Type or Print In Black Indelible ink. Assure All Copies Are Legible.

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| ner | 4e Facility Name (II | | ALC: CON | | r) | | | | | cation of Deaft | | | |
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| | 214-12-57 Usual Residence of | 752 | 1X M | | 7,8 | Yrs. | Months Da | | Min. | 8. Dete of Bir (Month, De MAR. 8 | y, Year) , 1921 | MARY | ce (Steta or Foreig) LAND |
| | 10a. State | 10b. County | | | 10c. Cit | y, Town or Loc | cation | | | | | 10d | l. Inside City Limits |
| חופרוסו | MD | TA | LBOT | | 1111 | EASTO | N | | | | | | 1∭ Yes 2□ No |
| | 10e. Streef and Nun | mber | | | | | 10f. Zip Cod | e | | | 10g. Citizen of V | Whet Country | n |
| | 222 N. | AURORA | | | | | | 1601 | | | USA | | |
| | 11. Marital Status 1 XX ever Marri 3 □ Widowad | | ied 1 | Vas Decedar Irmed Forces X Wes 2 D Yes, Give 'aar or Datas | s?] No | 1 | Vas Decedant Yas, specify C | of Hispanic Ori Cuben, Mexicar No Specify: | n, Puerto I | cify Yes or No Rican, etc.) | Biad | e - Amarican ck, White, etc | 3. |
| ŀ | /Snec | 15. Decedent | | | | 16e. Deced | enf's Usual Oc | cupation ne durina mos | t of working | na | 16b. Kind of Bu | usiness/Indu | stry |
| ŀ | Elementary/Secon | | Ť | college (1-4o | r 5+) | | | ne during mos tired) | | | | | |
| | 12 | /Eiret Middle | l act) | -0- | | PAYRO | LL INVE | ESTIGAT | | /First Middle | Meiden Sumen | | MENT |
| | THOMAS J. | | | SR. | | | | EMI | LY BI | LANCHE | WEBER | | |
| | 19e. Informent's Na | | | | OTITE | | | | | | er, City or Town, | | oda) |
| ŀ | THOMAS J. | | NEK, | JK/ Dr | | Plece of Dispos | | | RUAD, | Date | N, MD 2 | | State |
| | 1 Burial 2 4 Donation | ☐ Cremation 5 🖾 Other (S) | pecify) | in sta | te | cematery, crem | etory or other | plece) | | | | | |
| | 21. Signature of Fu | inglal Service L | licensee Wad | le, Di | recto | | Name and Acate An | | Soard 2120 | | . Baltim | ore St | treet |
| 1 | 23a. Part1. Enter th | he diseese, or rt failure. List | complication | ns that caus | ed the deat | h. Do nof ente | or the mode of | dying, such as | cardiec o | r respiratory a | rrest, | A | opproximate nterval Between |
| Examiner | resulting in death) | | / | cha | Due to (d | or es e conseg | uence of): | , | - | | | | |
| 10000 | Sequentially list confirming to impact the cause. Enter Under Ceuse (Disease or that initiated events resulting in death) L | 5 | c | 2000 | | or as e consequent | | chie | Pu | lmonu | iry Dis | ese | 7Wyr. |
| | thet initieted events | 5 | C | | | | | chre | PU | Inona | iry Dis | ese | TWYI |
| | thet initieted events | Last | | ting to death | Due to (o | or as a consequ | uence of): | | | 23b. Dfd | | entribute to t | ha cause of death |
| | resulting in death) L | Last | | ting to death | Due to (o | or as a consequ | uence of): | | | 23b. Dfd | tobacco use co | 3 Proba | bly 4 Unknown a autopsy findings able prior to plation of cause |
| | resulting in death) L | Last | | ting to death | Due to (o | or as a consequ | uence of): | | | 23b. Dfd | tobacco use co Ves 2□ No | 3 Proba 24b. Were avail comported to de | bly 4 Unknown a autopsy findings able prior to plation of cause |
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| פ בפ בפווילייבים בל ביו ול פוביות וועיביובים | Pert II. Other signification | Cast from condition from the condition from | ins contribut | 7 | Due to (o | or as a consequ | uence of): | e given in Part | f. | 23b. Dfd 124e. Wes perfo | tobacco use co Ves 2□ No sen eutopsy omed? | 24b. Werr avail compor de | e autopsy findings able prior to plation of cause sath? |
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| | 1. Decedent's Name (i | First, Middle, Last | 1) | | Month | | | | | 2. Date of D | | | V | 3. Tima of Death | • |
| ician | Ruth | Catheri | ne F | uchs | | | | | | Month Janua | Dey | | Year 000 | 9:15pm | |
| dical niner | 4a Facility Neme (If no | ot institution, give | street and nu | mber) | | | | 4b. City, To | wn, or Lo | ocation of Dea | | | of Death | 9:13011 | i |
| HHIC | Stella M | | | | | | | Timor | 2 i 1 m | | | | | | |
| - | 5. Social Security Num | | | 7 Ann /In vn | s. last birthday) | If Unde | er 1 Year | | | 8. Date of B | | ball | 1 More | e lace (State or Foreign | _ |
| al or | 214-03-682 Usual Residence of De | 4 | M 20 F | 91 | Yrs. | Months | | Hours | Min. | (Month, D Aug. 1 | lay, Year) | 908 | Coun | yland | |
| | | 0b. County | | 10c. C | City, Town or Lo | ocation | | _ | | | | | to | 0d. Inside City Limits | |
| Director | Manual and | D=1+1 | | 01100 | _ | | | | | | | | | 1 ☐ Yas 2 ☐ No | |
| Directo | Maryland | Baltimo | re | | Towson | 7 | | _ | | | 40 000 | | | X | |
| | 10e. Street and Number 205 E. J | | d Apt | . 1802 | | | ip Code 1286 | | | | | .S.A | /hat Couni | try? | |
| by Funeral | 11. Maritel Status 1 Never Merried 3 Vidowed 4 | | 12. Was Dece Armed Fo 1 Yes If Yes, Giv Year or D | edent Ever in rces? 2X No | | Was Deci If Yes, sp | | dispanic Ori an, Mexicen Specify: | gin? (Spo , Puerto | ecify Yes or N Rican, etc.) | | | - America k, White, a | | |
| Completed | .15 | 5. Decedent's Edu | cation | | 16a. Dece | dent's Us | ual Occup | pation | | | 16b. Kin | nd of Bu | siness/Ind | lustry | - |
| ple | (Specify Elementary/Seconds | only highest grad | , | Ann Eal | (Give | DO NOT | ork done use retire | during mos | t of work | ing | | | | | |
| E | 11 | ary (0-12) | College (1 | 1-40f 5+) | Cash | ier | | | | | 1 | Merc | V HOS | spital | |
| | 17. Father's Neme (Fir | rst, Middle, Last) | | | 1 0000 | | | 18. Mothe | r's Neme | (First, Middle | | | | SPICAL | |
| Be | Tomo = | | | | | | | | | | | | | | |
| To | James | Lest | | | | | 400 | | | ine | | | | | |
| | 19a. Informent's Neme | | | | | | | | | al Route Numi | | | | Code) | |
| | Mrs. Joan | M. Brahi | m/Daugl | | | - 4 | | od Lar | ne I | Timoniu | im, Mo | 1. 2 | 1093 | | |
| | 20e. Method of Dispos | | | | Place of Dispo | osition (Ne | other pla | ce) | | Date | 20c. Loc | cation - (| City or To | wn, Stete | ĺ |
| | 1 Donation 5 | | | | laney | | | | 272/2 | /2000 | Time | an i i i | m, Mo | a | |
| | 21. Signature of Funer | | 11 1 | 7 | | | | ss of Facilit | - | 2,2000 | TIME | JIIIu | itt, Pic | | |
| | | 1/7 | // | / | - | c. Ivallio a | IN AUGIE | ISS OF ECHIC | у | | | 105 | O You | rk Road | |
| | Can | (X.) | and | /, | R | uck ! | Tows | on Fur | neral | Home, | Inc. | . Tow | son, | Md. 21204 | А |
| | 23a. Pert1. Enter the | displate, or ompi | ications that c | and the later of t | | | | | | | | | | | * |
| | | aildfa. List-only o | ne course on e | ach line | ath. Do not ent | ter the mo | de of dyir | ng, such es | cardiac o | or respiretory | arrest, | | | Approximate | 4 |
| | | / | // | | | | | // | cardiac (| or respiretory | arrėst, | | | Approximate Interval Between Onset and Deeth | 1 |
| | Immediate Cause (Fin disease or condition resulting in death) | / | // | <3× | do n | 44 | est h | 4 | cardiac (| or respiretory | arrest, | | : | Interval Between | - |
| Iner | Immediate Cause (Fin disease or condition | / | // | <3× | | 44 | est h | 4 | cardiac (| or respiretory | arrest, | | | Interval Between | 75 |
| Examiner | Immediate Cause (Fin disease or condition resulting in death) | nal (| // | Duay P | do n | quence of |): (E)/3 | 4 | cardiac (| or respiretory | arrest, | | | Interval Between | 7 |
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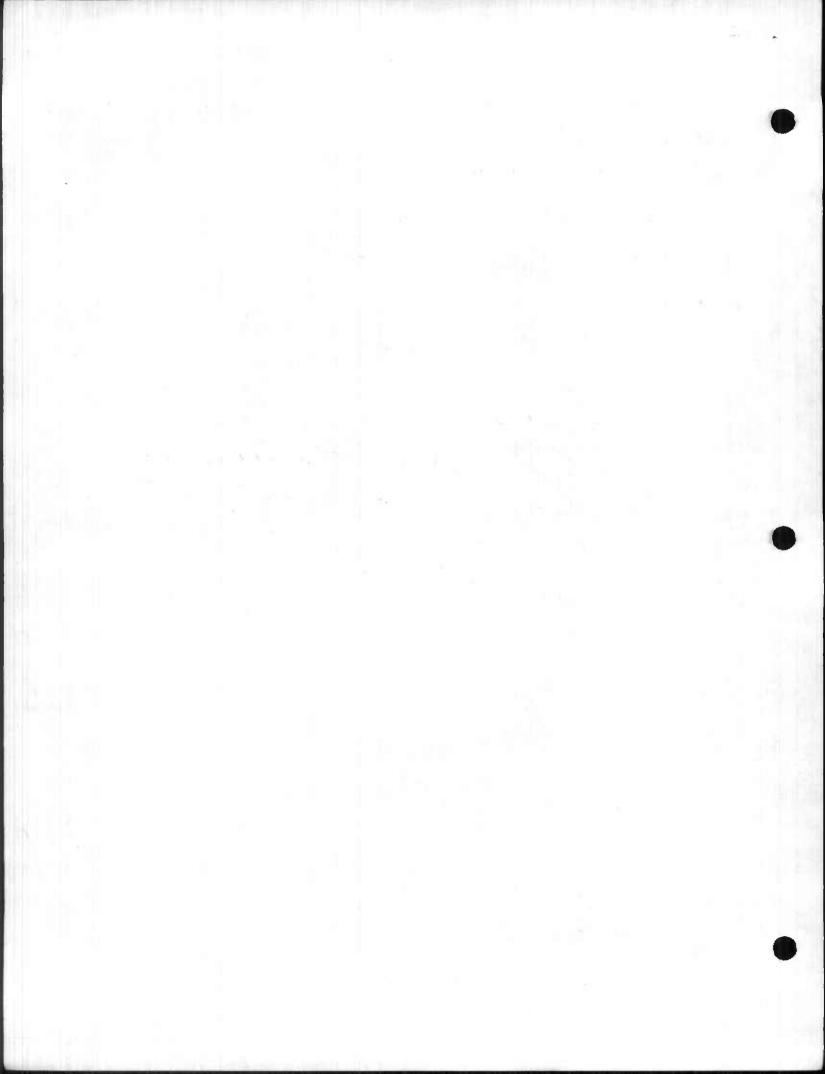
DHMH 16 Ray 6/95

State Registrar

Eddie Nakhuda, M.D.

FUCHS, RUTH

2300 Dulaney Valley Rd Timonium, Md 21093

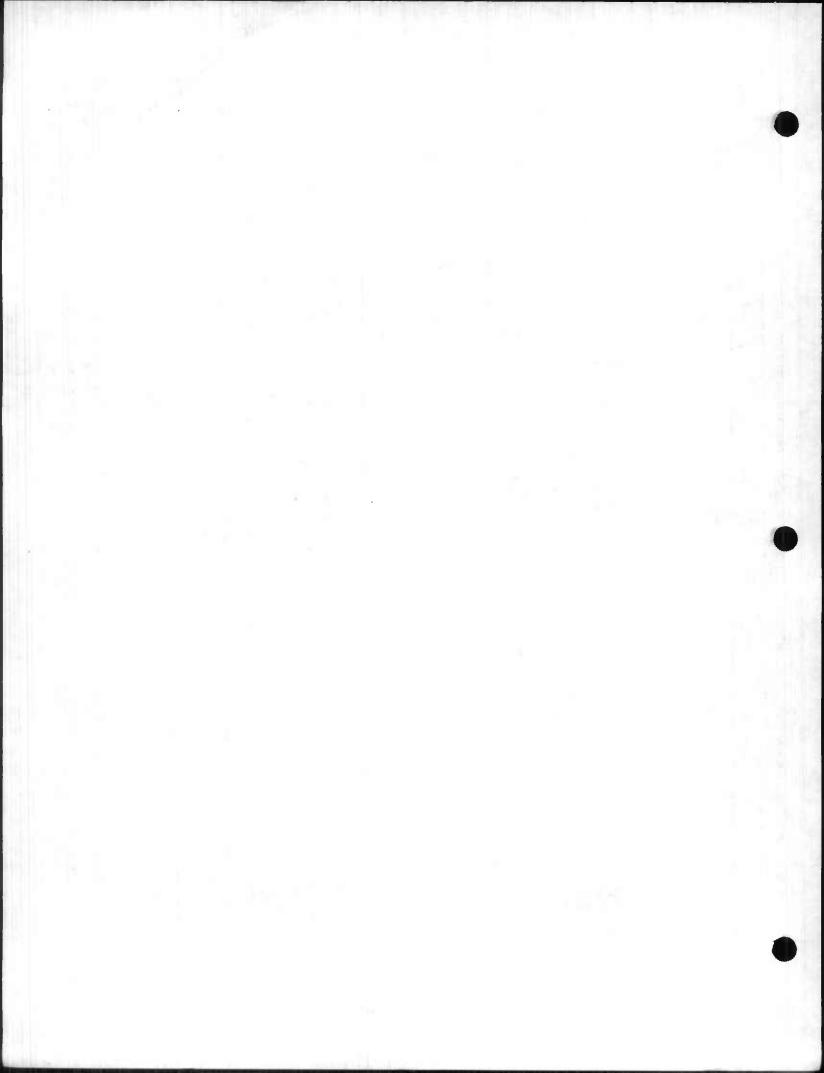


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State of Maryland / Department of Health and Mental Hygiene

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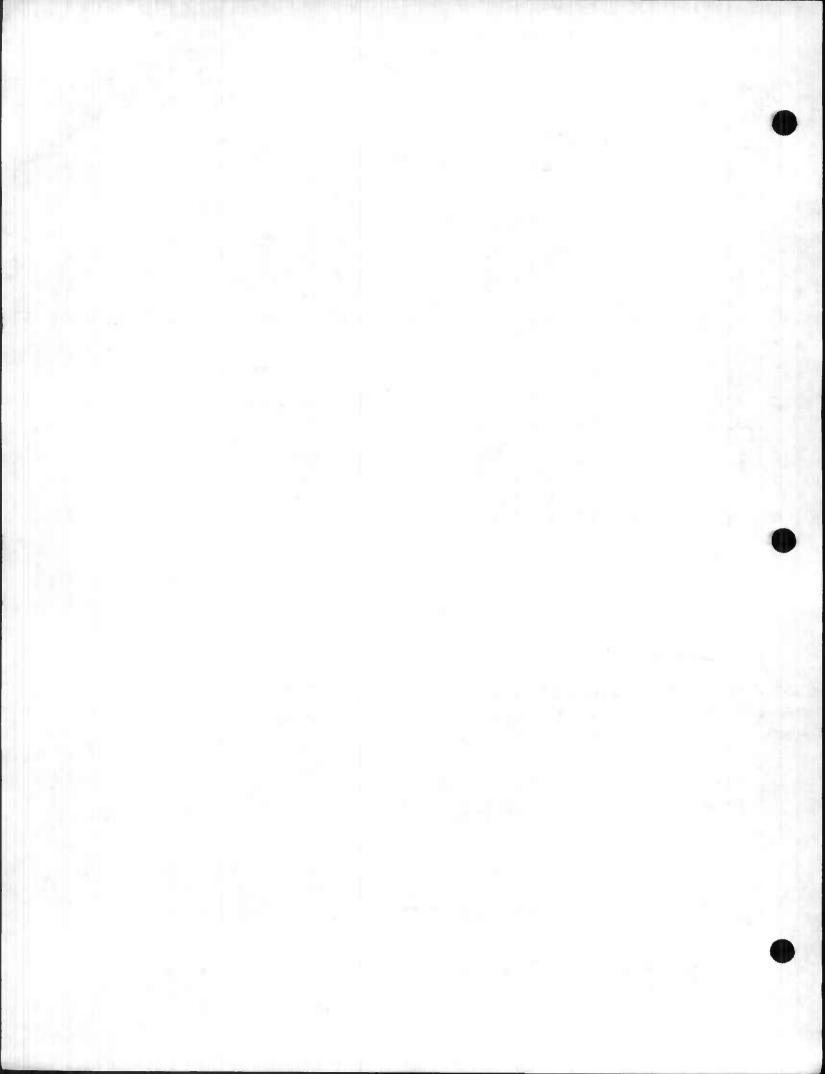
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| | 1. Decedent's Neme (rirs | t, Middle, La | ist) | | | | | | | 2. Dete of De Month | | | Vee | 3. Time of Death |
| an | Mary Read | F | austma | n | | | | | | _ | Day | , | Year | 3:10 p.r |
| al | 4a Facility Neme (If not in | | | | | | | 4b. City, To | wn, or Lo | January cation of Deat | | | of Deeth | 0.10 5.1 |
| er | 16 Beehive | | | | | | | 0 1 | | . 1 1 | | | | |
| | 5. Social Security Number | | Apt. | _ | yrs. last birtho | daul | If Under 1 Yee | | eysv 24 Hrs | ille | rth | ва | 1timo | |
| | | | 1 M 2 F | 7. Age (m | . V- | N | Months Deys | | Min. | 8. Dete of Bi (Month, De | | | Coun | lece (State or Forei |
| | 216-09-1114 Usual Residence of Decer | dont | | | 83 " | | | | | Nov. 2 | 5, 19 | 916 | | Md. |
| 1 | | County | | 100 | . City, Town o | or Locat | tion | | | | | | 1 | Od. Inside City Limit |
| * | | | | | | | | | | | | | | 1 ☐ Yes 2 ☑ N |
| Directo | | Balti | more | | Cockey | | | | | | | | | |
| É | 10e. Street and Number | | | | | | 10f. Zip Code | | | | 10g. Citi | izen of V | Vhat Cour | nfry? |
| in local in a | 16 Beehive | Place | Apt. D |) | | | | 21030 | | | | USA | | |
| 1 | 11. Merital Status | | 12. Was Dec | | In U,S. | 13. We | s Decedent of es, specify Cul | Hispenic Ori | gin? (Sp | ecify Yes or No | 0- | | e - Americ | |
| | 1 Never Merried 2 | □ Married | 1 Tes | 2 🖾 No | 194 | | Yes 21 No | | , , , , | 1110211, 010.7 | | | | otc. |
| 1 | 3 ₩ Widowed 4 □ D | ivorced | If Yes, G Yeer or I | Detes: | | 10 | J 195 ZKING | э эреспу. | | | | Specify | Whi | te |
| Ì | 15. D | ecedent's E | ducation | | 16e. D | eceden | nt's Usuel Occu | petion | | | 16b. Ki | ind of Bu | usiness/In | dustry |
| | | | ade completed | | 10 | Give kin ife. DO | nd of work done NOT use retire | e duning mos red) | t of work | ing | | | | |
| | Elementery/Secondary | (0-12) | College | (1-4or 5+) | Acc | sist | ant | | | | Nin | rsin | a | |
| ŀ | 17. Father's Neme (First, I | Middle, Lasi | () | | noc | 3136 | ant | 18. Mothe | r's Nem | e (First, Middle | | | - | |
| | | | | | | | | | | | | | | |
| | Edgor | | | | Wiest | | | | lian | | | | 04 | Sachs |
| | 19e. Informani's Neme/Re | | | | 19b. N | Mailing / | Address (Stree | | | | | | | |
| | Mr. William | R. Fa | ustman/ | | | | orval . | | Uppe | r Marl | | | | |
| | 20e. Method of Disposition 1 ☑ Burial 2 ☐ Cren | | | 2 State | Ob. Plece of D cemetery, | Dispositi cremet | ion (Neme of tory or other pl | ace) | | Dete | 20c. Lo | ocation - | City or To | own, Slate |
| | 4 Donetion 5 DO | | | | oudon | Dar | k Ceme | tory | 1 | /31/00 | Ro1 | 1 + i m. | oro | Md |
| 1 | 21. Signature of Funeral S | Service the | nsse co | | Loudon | | Neme end Addi | | | 1-11/00 | DaJ | 10 | ore, | rk Road |
| | A POTO | 1 | 512 | 1 | | | | | | | | | | Md. 21204 |
| | Immediate Cause (Fine) | | | | | | | ying, such es | cardiac | or respiratory | | | 1, | Onset and Deeth |
| Medical | Immediate Cause (Finel disease or condition resulting In deeth) Sequentially list condition if any, leeding to immedia cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest | is, ete | | Due Due | | EO | ance of): | | Cardiac | | | | | |
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State of Maryland / Department of Health and Mental Hygiene

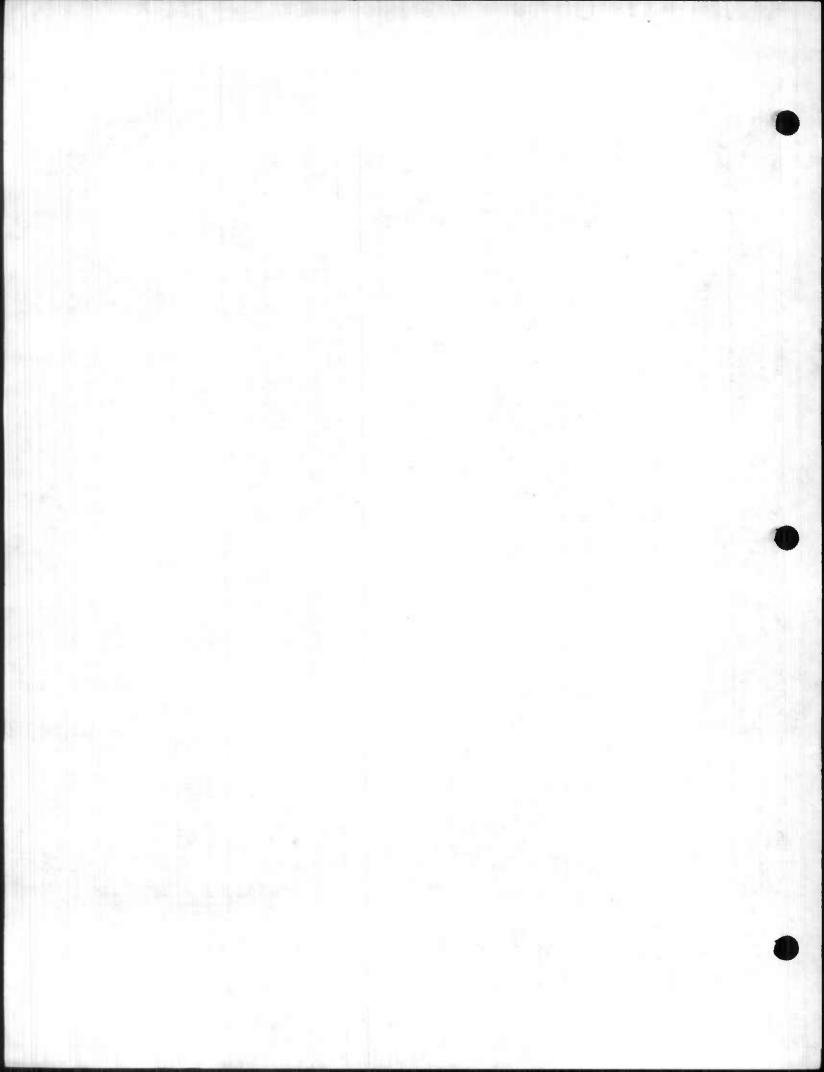
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| Medical | | YEFIM | | | F | AYBUS | | | JANUAR | | 000 | 8:40 | AM |
| xaminer | | If not Institution, give ZINA COUR! | | r) | | | | OWINGS | | BALT | | | |
| neral ector | 5. Social Security N 219-39-0 | 0423 | 7. A | ige (In yrs. 46 | last birthday) Yrs. | If Under Months | | If Under 24 Hrs Hours Min | | 1953 | 9. Birthpla Countr | RUSS | |
| | Usuet Residence of 10a. Steta | 10b. County | | 10c. Cit | y, Town or Loc | ation | | | | | 100 | d. Insida C | |
| be notified Director | MD | BALTI | MORE | OV | VINGS M | | | | | | | 1 Yas | 22J N |
| at be n | 10e. Street and Nu 12 RO | mber ZINA COUR' | r | | | 10f. Zip | Code | 21117 | | 10g. Citizan of V RUSSI | | y? | |
| dical Examiner must be notified at sted by Funeral Director | 11. Marital Status 1 Never Marr 3 Widowed | ied 2 Merried 4 □ Divorced | 12. Wes Decedent Armed Forces 1 Yas 2 If Yes, Give Year or Datas | ? No | | /as Deced Yes, spec | | lispanic Origin? (S an, Mexican, Puar Specify: | Specify Yes or No- to Ricen, etc.) | 14. Race Blace Specify | - America k, White, at | | re |
| A, the Medical I | (Spec | 15. Decedent's Ed city only highast gra- ondery (0-12) | ucation da completed) College (1-40) | r 5+) | 16a. Decede (Give k life. D | O NOT us | ol Occup rk done se retire | petion during most of wo d) | orking | 16b. Kind of Bu | | | |
| A S | 17. Fether's Neme | (First, Middle, Last) | | | וחניוםככאן | | | 18. Mother's Ne | me (First, Middle, | | | TEMMI | 10 |
| To Be | NATHAI | | | | FAYBUS | OVICE | I | YENTA | | | SHUL | MAN | |
| - | | eme/Reletionship (7 | | | | | | | lural Route Numbe | | | Code) | |
| 2 | | A FAYBUSO | VICH / WI | FE | 12 RO | | | URT - OW | INGS MIL | 20c. Location | | m Ctata | |
| ry or of | | position □Cremation 3 □ 5 □Other <i>(Specif</i>) | | | cemetery, crem | etory or o | ther ple | | Y 1/23/0 | | STERSI | | MD |
| any inj | 21. Signeture of | Service Licen | 5 | | | | | ss of Fecility | | EVINSON | | | |
| 0 | 23a. Part1. Enter t shock, or hee | he disease, or comp ort failure. List only | ticetions that causone cause on each | ed the deet line. | | | | | N ROAD — | | | Approximate the constant and | te tween |
| ician dical niner | tmmediete Cause disease or condition resulting in death) | (Finat | RENAL | CELL | CARCING | AMC | | | | | | L YEAR | |
| <u> </u> | rooding in ooding | | | Due to (d | or as a consequ | uence of): | | | | | 1 | | |
| Examiner | Sequentially list co if eny, leading to in ceuse. Enter Unde | enditions, nmediate artying | b | Due to (| or as a consequ | uence of): | П | | | | | | |
| e as the burial-transit Medical Examir | Cause (Disease or that initieted events resulting in death) | injury | c | Due to (d | or as a consequ | ience of): | | | | | | | |
| for use a | | | | | | | | | 1 201 511 | | | | |
| ached hysi | Part II. Other signif | licant conditions co | entributing to death | but not res | ulting In the un | derlying c | ause giv | ven in Pert I. | | tobacco usa co Yes 2□ No | | 7 | |
| should be leted by | | | | | | | | -4.3 | | an autopsy med? | ava | re autopsy ilable prior appletion of leath? | to |
| Page 2 | | | | | | | | | 101 | res 25 No | 10 | Yes 2 |] No |
| rector, pa | 25. Was case reference | rred to medicat | | | | | | 26. Place of De | eth (Check only o | ne) | | | |
| To Be | 1 Yas 22 | No | Hospital: 1 Inpa | tiant 2 | ER/Outpatient | 3□ DC | DA Oti | her: 4 Nursing | Home 510 Resid | X Residence 6 □Other (Specify) | | | |
| fune | 27. Menner of Deat 1 XXNaturel 2 Accident | h 5 Pending investigetion | 28a. Date of In (Month, L | | 28b. Time of Injury | M 2 | 8c. Inju Wo 1 □ | ryat rk? ∣Yes 2 □ No | 28d. Describe | how injury occurred | | | |
| completely filled in by the funeral Medical Certification: | | | | | | | | | er or Rural | Routa Nun | n <i>ber</i> , | | |
| dical | 29e. Cartifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and place, end due to the cause(s) and main control one. 29e. Cartifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and menner steted. | | | | | | | | | annar as sta and due to | ated the ceuse(| s) | |
| Me | 29b. Signeture and | title of certifier | | | | 290 | c. Licens | se number | | 29d. Dete signe | d (Month, E | Day, Year) | |
| ~ | > Swin | Miam Bes | udict, 7 | | | | | D000858 | 3 | 1/21/2 | 2000 | | |
| | _ | esa of person who | | | | | | | | | | | |



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State of Maryland / Department of Health and Mental Hygiene 12485

| | | | | Cer | tificate of | Death | | Reg. No. | 0 02300 | |
|------------|--|---|--|------------------------------|---|-------------------------|----------------------------------|-------------------------------|--|--|
| | Dhusisian | 1. Decedent's Nama (First, Middla, La | ist) | | | | 2. Data of E Month | Death Day | 3. Tima of Death | |
| | Physician /Medical | Jose L. Ari | as Flores | | | | Januar | cy 23 2 | 000 11:02 P.M | |
| | Examiner | 4a Facility Name (If not institution, gl | | | | 4b, City, Tow | n, or Location of Dea | 4c. County | of Death | |
| | | | Adventist Hosp | na Park | gamery | | | | | |
| | Funeral | | Sex 7. Aga (In yrs. | | If Under 1 Yaar Months Days | Hours | Min. (Month, L | Day, Year) | Birthplaca (State or Foraign Country) | |
| | Director | 5/9-1/-/11/ | 26 | Yrs. | | | Augus | t 7,197 | 3 ElSalvador | |
| | Pu s | Usual Residence of Decedent 10a. Stata 10b. County | 10c. Cit | | | 10d. Inside City Limits | | | | |
| | Aanyl or or | Man-1 4 Dodge | | | to was 2 □ No | | | | | |
| | or 28a-f | Maryland Princ | e George Hy | attsv | 101. Zip Coda | | | 10g. Citizen of What Country? | | |
| | With Po of I | | | | 2078 | 3.2 | | | States | |
| | 72 hours after death with the Maryland natural; or frems 23s or 28s-1 show deal Examiner must be notified at etch by Funeral Director | 11. Maritel Status | 12. Was Decedant Evar in U | S. 13. V | Vas Dacedenf of H | lispanic Origi | n? (Specify Yas or h | | - Amaricen Indian, | |
| 0 | Fur Fur | 1 Never Married 2 Married | Armed Forces? 1 ☐ Yas 2 ☒No | H | Yas, specify Cubi | an, Maxicen, | Puarto Rican, atc.) | Blac | k, Whita, atc. | |
| 070 | ors o | 3 ☐ Widowed 4 ☐ Divorced | If Yes, Giva Yaer or Datas: | | Yas 2□ No | Specify: | ElSalva | dor Specify. | White | |
| 21215-0020 | od within 72 hours ygiene. wr then "neturel", ft. fr. Model E., Completed by | 15. Decedant's E | ducation | 16a. Deced | lent's Usuel Occup | ation | of working | 16b. Kind of Bu | sinass/Industry | |
| 21 | within 7 | (Specify only highast gri | Coflege (1-4or 5+) | life. C | OO NOT usa retired | d) | or working | | | |
| 21 | Hyglene. Hyg | 12 | | Wa | iter | | | Rest | urant | |
| pu | EISE a | 17. Fathar's Name (First, Middle, Last | | | 11 100-100 | | s Name (First, Midd | la, Maiden Sumam | a) | |
| yla | De se | Manuel Flores | | | | | | cias | | |
| Maryland | 2 sh and le m | 19a. Informent's Name/Ratationship (| | | | | or Rural Route Num | | | |
| | s 1 and f Heelth Nem 27 other tr | Manuel Flores | | | | т пу | attsvill | 7 | | |
| altimore, | Pages 1 a nent of Her art: If Nem ary or othe | 20a. Mathod of Disposition | Ramoval from Stata | ematary, cran | sition (Nama of natory or other plac | | Data | | City or Town, State | |
| E | Part: | 4 Donetion 5 Other Special | | ate of | Heaver | 1 Cem | . 1/28 | Silve | r Spring,MD | |
| Ball | permit. Pages Department of Important: If It any Injury or of pages | 21. Signature of Conegal Bervide Lice | nsee | 22 | . Nama and Addra | ss of Facility | Takoma | Funera | 1 Home. | |
| ш | E S Z C Z | 1 /John | Marker | 2 | 54 Carı | :011 | St. NW W | ashingt | on, DC. 20012 | |
| | | 23a. Part1. Entar the disaase, or comshock, or haart failura. List only | plications that caused the daat | h. Do not ente | er the mode of dyir | ng, such as c | erdiac or raspiratory | arrest, | Approximate Intarval Batween | |
| | Physician | | | | | | | | Onset and Death | |
| | /Medical Examiner | Immediata Causa (Final disaase or condition | . Multiple | Triurie | 5 | | | | | |
| | ALC: UNK | resulting in death) | a. Multiple 1 Dua to 19 | as a conseq | uance of): | | | | | |
| | executed in and ial-transit | | b | | | | | | | |
| | certificate be executed rding physician and use as the bunal-transit and water and the control of the control o | Sequentially list conditions, if any, laading to immediata | Due to (c | or es a conseq | uence of): | | | | | |
| 68760, | be ed ician buria | | C | | | | | | | |
| 387 | entificate be ling physicit e as the bu | thet initiated events rasulting in death) Last | Due fo (o | r es a consequ | uenca of): | | | | | |
| × | nding use as | | d | | | | | | | |
| Bo | for for | | | | | | | | | |
| o. | the the | Part II. Other significant conditions of | contributing to death but not ras | ulting in tha ur | ndarlying causa giv | an in Part I. | | | ntribute to the cause of death? | |
| 0 | E # 0 - | | | 7.0 | | | 11 | Yes 22No | 3 Probably 4 Unknown | |
| Records, | 2 22 2 | | | | | | 24a. W | as en autopsy | 24b. Were autopsy findings | |
| 20 | been s should | | | | | | | rformed? | available prior to completion of cause | |
| Re | The law requir | | | | | | | of | of death? | |
| ā | delan: The I certificate hi rector, page | | | | | | | Yes 2□No | 108 Yas 2□ No | |
| Vital | Physician: this certific ral director, To Be (| 25. Was cesa rafarrad to medical axaminar? | Hospitel: | State : it | . 3CL DOA Oth | ar. | of Death (Check on) | | 40 4 4 | |
| of | £ £= - | 1 X Yes 2 No 27. Mannar of Death | 28a. Data of Injury | ER/Outpatien 28b. Tima of | I SU DON | TI INUIS | sing Homa 5 ☐ Re 28d. Dascrib | e how injury occurr | | |
| Division | Attending Process. After by the funer | 1 Natural 5 Pending 2 Accidant invastigatio | (Month, Day Year) | Injury 2230 | Wor | Yas 200 N | | | accident | |
| S | l or Attendi after death Director: A d in by the f | 3 Suicida 6 Could not b | e one Pleas of John Ath | | | | 00/ 1 | 104 | | |
| É | Paris T | 4 Homicide | building, afc. (Specif | y) | 1. | | Universi | Ty Blue nea | or Piney Branch Rel | |
| | Hospital Hospital Hospital Hospital Hospital Hospital Hospital Hospital Hospital | 29a. Certifier 1 Certifying Ph | ysician: To the best of my kno | wiedga, daath | | na, data and | place, and dua to th | a cassa(s) and ma | nner as stated. | |
| | ne Hoep n 24 hou ne Funer pletely fill edical | (Check only 2 Medical Exar | niner: On the basis of axamina and mannar stated. | tion and/or inv | astigation, in my o | pinion, deeth | occurred at the tim | a, data and place, | and due to the causa(s) | |
| | To the Hospital or Att within 24 hours after of To the Funeral Direct completely filled in by Medical Certifi | 29b. Signatura and titla of certifiar | | | 29c. Licans | e number | | 29d. Date signed | d (Month, Day, Year) | |
| 3 | - > - 0 | 1 | Maken | | 0.0 | .M.E. | | Janua | my 24 2000 | |
| | / | 30. Name and address of person who | complated cause of death /Itan | n 23a) (Type | | , errelie | | Gariua | ry 24, 2000 | |
| , | 6 | Dennis J. C. | huteno | | | treet. | Baltimon | e, Marvl | and 21201 | |
| | State | 31. Data filed (Month, Day, Year) | 32. Registrar's Signa | | | | | | | |
| | Registrar | FER 0 1 2000 | Sunce & | do | aller. | | | | | |



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Deeth 3. Time of Death Year Month **Physician** Rebecca Feild 10:30a.m. 24 2000 01 /Medical 4a Facility Name (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Death Examiner 120 Melvin Avenue Catonsville Baltimore If Under Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 M 2 F Yrs. 219-18-4741 77 Director 02 05 MD Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Directo Baltimore 28a-f Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Barrie 23a or 120 Melvin Avenue 21228 USA Funeral 14. Race - American Indien, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 72 hours after 1 Yes 2 No 1 Never Merried 2 Merried 21215-0020 "natural", or Specify: White 1 ☐ Yes 2 No Specify: à 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry filed within 7 Hyglens. Other than "n Elementary/Secondary (0-12) College (1-4or 5+) 12 Own Home Baltimore, Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Pages 1 and 2 should be fill ment of Health and Mental H tankt if Item 27 is marked off lury or other traumatic even Be Henry M. Stromberg Edna Ray 19a. Informent's Neme/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Bryant/daughter 1502 Ivanhoe Avenue, Catonsville, Md21228 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Data 20c. Location - City or Town, State 1 Burial 2 Cremetion 3 Removel from State 4 ☐ Donation 5 ☐ Other (Specify) 01 27 New Cathedral Cem Baltimore, Md. 21. Signeture of Funeral Service Licensee 22. Name and Addrass of Fecility Sterling Ashton Schwab Funeral Home, Inc 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or haart failure. List only one cause on each line. 21228 Approximate Intervel Between Onset and Death **Physician** /Medical Immediate Cause (Finel ATHEROSCICROTE CARDIOVASCULAR DISCASS disease or condition resulting in death) Examine Due to (or as a consequence of): Examine DIABETES MELLITUS YCARS physician and s the buriel-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) the deeth certificate be Physician/Medical that initiated events resulting in death) Last Due to (or as a consequence of) Box USB I 23b. Did tobacco use contribute to the cause of death? detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 1 Yaa 2 No 3 Probably 4 Unknown Records, à 60 The law requires 24b. Wara autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 Yas 2 No 1 Tyes 2 No of Vital Be 25. Wes case referred to medical 26. Place of Deeth (Check only ona) To Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No this funeral 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? Certification: Division After 1 Natural Attending 5 Pending invastigation n 24 hours efter death.
The Funerel Director: Aft 1 Yes 2 No 2 Accident 6 ☐ Could not be detarmined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stata) 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide 6 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and mannar as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical To the Hosp within 24 hor To the Fune completely fi (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) Chit 1. Ca 00025844 1-25.00

Registrar

State

31. Dete filed (Month, Day, Year)

FEB 0 1 2000

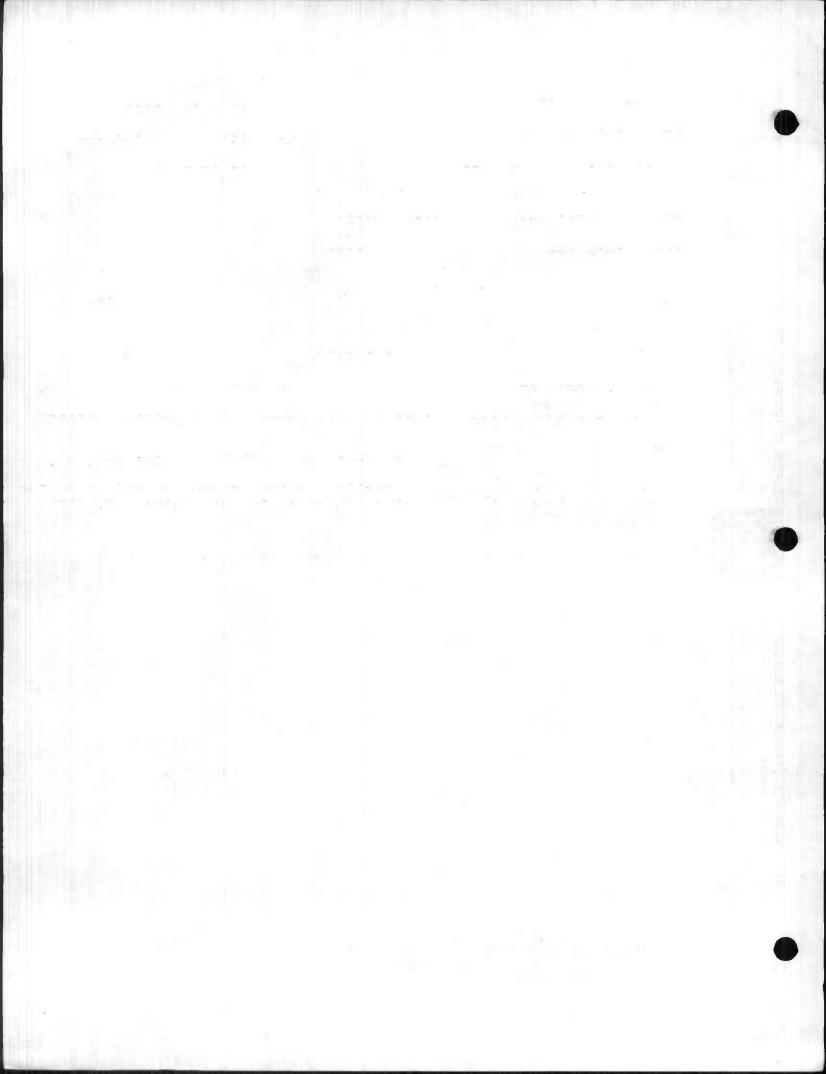
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32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SYII OLD FREDERICKED #18 BILTHORE, MO

Spark

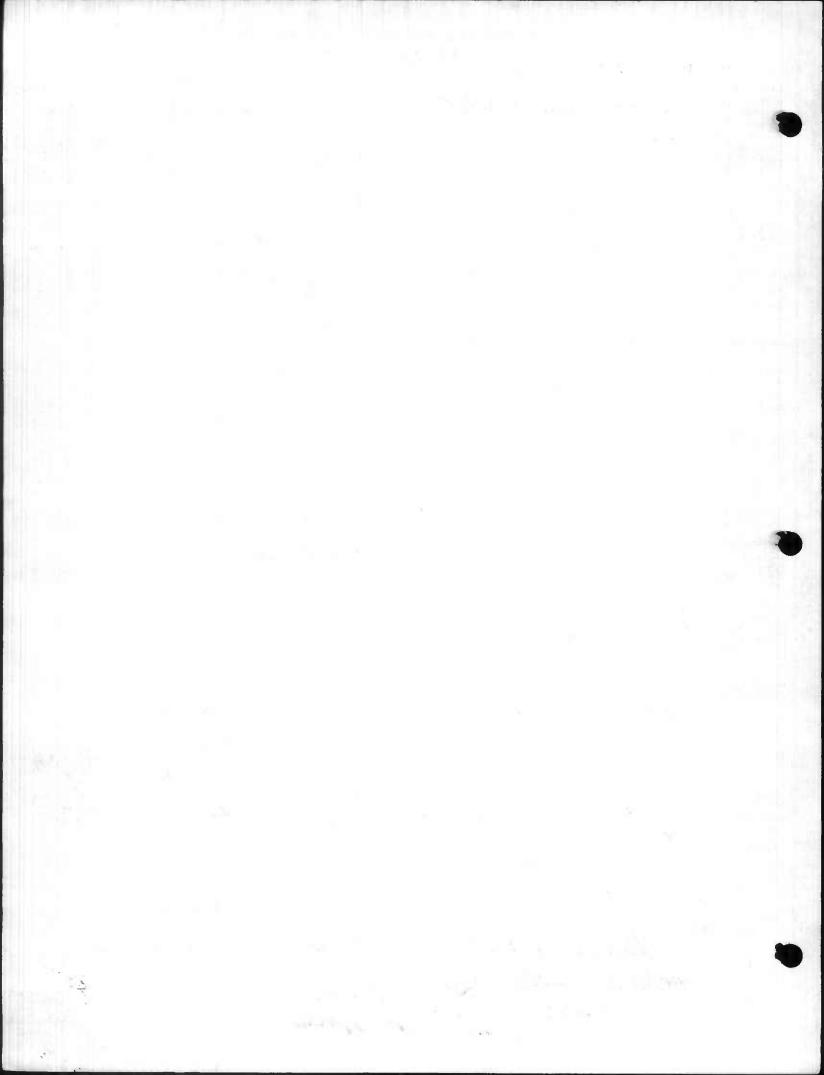


Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible.

| | Amen | ded | Item#26 perFHG780 2/1/20 | | ryland / l | Department of Certificate of | | and Mental H | ygiene () Reg. No. | 0 02487 |
|------------|--|-----------------|---|---|------------------------------|---|------------------------------------|---|--|---|
| П | Physic | ian | 1. Decedent's Neme (First, Middle, Last) | For | 60 | | | 2. Date of E Month | eeth Day | 3. Time of Death |
| 9 | /Medi | cal | CLARA MARIE | | 61 | | 4.00.7 | Januar | | |
| | Exami | ner | 4e. Fecility Neme (If not institution, give st 2148 Chesapeake F | | 1110 | | Annap | wn, or Location of Dea | | |
| Н | Funeral | | 5. Social Security Number 6. Sex | | LVE (In yrs. last bii | thday) If Under 1 Y | 1 4- | 24 Hrs O Date of B | lette. | Arundel Co. |
| | Director | | 218-09-0529 | | 36 | Yrs. Months D | eys Hours | Min. (Month, L May 07 | lay, Year) | 9. Birthplace (State or Foreign Country) Maryland |
| | show | | 10a. Stete 10b. County | | 10c. City, Tow | n or Location | | | | 10d. inside City Limits |
| | e Ma | ctor | Md. Anne Arur | ndel Co. | Arno | old | | | | 1 ☐ Yes 2X No |
| | th with th | ai Director | 135 Brent Road | | | 10f. Zip Coi 2 | 1012 | | 10g. Citizen of | What Country? USA |
| 020 | Z1Z15-UUZU within 72 hours after death with the Maryland jene. riben "natural", or items 23a or 28a-f show the Motical Examiner must be notified at | by Funeral | 11. Maritel Status 1 Never Married 2 Merried 3X Widowed 4 Divorced | 2. Was Decedent Ev Armed Forces? 1 Yes 2 No If Yes, Give X Yeer or Dates: | | 13. Wes Decedent If Yes, specify | Cuban, Mexicar | gin? (Specify Yes or N , Puerto Rican, etc.) | | a - American Indian, ck, White, etc. |
| 21215-0020 | ithin 72 ho le. lan "natur Mooical | Completed | 15. Decedent's Educi (Specify only highest grede Eiementary/Secondary (0-12) | ation completed) College (1-4or 5+) | | Decedent's Usual Od (Give kind of work do life. DO NOT use re | one during mos | t of working | | usiness/Industry Murray |
| CA | 70 70 10 100 | | 12 | 0 | Bo | ook Keeper | | | Dance | Studio |
| Maryland | of a by | Be | 17. Father's Name (First, Middle, Last) | | | | | er's Neme (First, Middl | e, Maiden Suman | ne) |
| 7 | d 2 should by | To | Thomas Owen Rose 19a. Informant's Neme/Relationship (Type) | e Print) | 10 | Malling Address /St | | ie Heline er or Rural Route Nurm | her City or Town | State Zin Code) |
| | d 2 s | | Karen R. McGuiness | | | - | | | | olis, Md.21403 |
| re, | | | 20a. Method of Disposition | | 20b. Placa o | Disposition (Name or ry, crematory or other | f | Date | - | - City or Town, Stete |
| E | Page tent o mt: If | | 1 ☐ Buriai 2 ☑ Cremetion 3 ☐ Re 4 ☐ Denation 5 ☐ Other (Specify) | movel from Stete | | Mount Cem | | 1/28/2000 | Baltimo | ore, Md. |
| Baltimore, | permit. Pages 1 Department of H Important: If its any injury or ot otics. | | 21. Signeture of Fundrai Service Licensee | | 1 , | 22. Name and A | | * | | |
| m | 88188 | | 1 Waniel | 7. 1/0 | w/s | | | iak Funera ve. Baltin | | |
| 6 | Physician /Medical Examiner | Je. | 23a. Part1. Enter the disease, or compilcontook, or heart failure. List only one immediate Cause (Final disease or condition resulting in death) a. | Conge | stive | Alast; | - 0 | | | Approximate Interval Between Onset and Death |
| 8760, | death certificate be executed e attending physician and ed for use as the burial-transit | ai Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury C. | Di | ue to (or as e | consequence of): | | | | |
| x 687 | eath certificata attending phys i for use as the | Wedical | that initiated events resulting in deeth) Lest | Du | ue to (or es e | consequenca of): | | | | |
| 9. O | that the ed by th detach | by Physician/Me | Part II. Other aignificant conditions control CAPONIC LUMG | | | n the underlying cause | given in Part I | | d tobacco usa co Yea 2□No | ontribute to the cause of death? |
| ec | law requires t as been sign 2 should be | Completed b | | | | | | | s an autopsy formed? | 24b. Were autopsy findings available prior to completion of cause of death? |
| - | The ate h | Con | | | | | | 10 | Yes 2000 | 1 ☐ Yes 2 No |
| Vital | Physician: The this certificate ral director, part | Be | 25. Wes case referred to medical examiner? | spital: | | | Othor | of Death (Check only | | 0 |
| ō | 0 0 | To | 1 ☐ Yes 2 No 27. Manner of Death | 28a. Date of Injury | | | | ursing Home 5 Re | | ner (Specify) Daughter's Residence |
| | Attending I r death. sctor: After by the funer | cation | 1 X Natural 5 ☐ Pending investigation | (Month, Day | | | njury at Work? 1 🗌 Yes 2 🗍 | The second second | how injury occur | red |
| DIX | tal or Attenders after deatl | Certification: | 3 Suicide 8 Could not be determined | 28e. Place of Injury building, etc. | / - At home, fa (Specify) | rm, street, factory, of | Ice | 28f. Location City or T | (Street end Numb own, State) | ber or Rural Route Number, |
| | To the Hospital or Attending Ph within 24 hours after Gash. To the Funeral Director: After th completely filled in by the funeral | edicai | 29a. Certifler (Check only one) 1 Certifying Physic 2 Medical Examine | cian: To the best of e er: On the basis of e and manner state | xamination an | , death occurred et the d/or Investigetion, in r | e time, dete an ny opinion, dea | d place, and due to the | e cause(s) and m e, date and place, | anner as steted. and due to the cause(s) |
| | To the within 2 To the comple | Σ | 29b. Signeture and title of certifier | 07110 | | | ense number | | | d (Month, Day, Year) |
| 3 | ; 1 | | · munitival | M MV) | | Do | 1386 | / | 1-2 | 1-00 |
| | 4 | | 30. Name end address of person who com THOMAS CUAUSH / 31. Date filed (Month, Day, Year) | pleted cause of dea | | (Type, Print) A | run k | 7 DOAD ARN | 1000 M | 021012 |

DHMH 16 Rav 6/95

Registrar



Box 68760, P.O.

Examiner sician and bunal-transit attending physician for use as the buna Physician/Medicai been signed by the should be detach Division of Vital Records. PY Completed certificate Be Certification: To

Physician

/Medical

Examiner

Funeral

Director

rai', or items 23a or 28a-f show Examiner must be notified at

"natural", or flems 23a or

Hygiene.

permit. Pages 1 and 2 should be filed w.
Department of Health and Mental Hygians Important: If Itam 27 is marked other tha any Injury or other traumatic across

Physician

/Medical

Examiner

filed within 72 hours after

altimore, Maryland 21215-0020

Director

Funeral

p

Completed

Be

To the Hospital or Attending Physicien: within 24 hours effect death.

To the Funeral Director: After this certifical completely filled in by the funeral director,

Medical

DHMH 16 Rev 6/95

State Registrar 4 Homicide

29b. Signatura and title of certific

31. Data filed (Month, Day, Year)

29a. Certifier

2000

124 N Wain St. Burlin



MO

mi

30. Nama and and and associated of person who completed cause of death (Item 23a) (Type, Print)

Continue Physician: To the best of my knowledge, daeth occurred at the time, date end place, and due to the cause(s) and manner as stated.

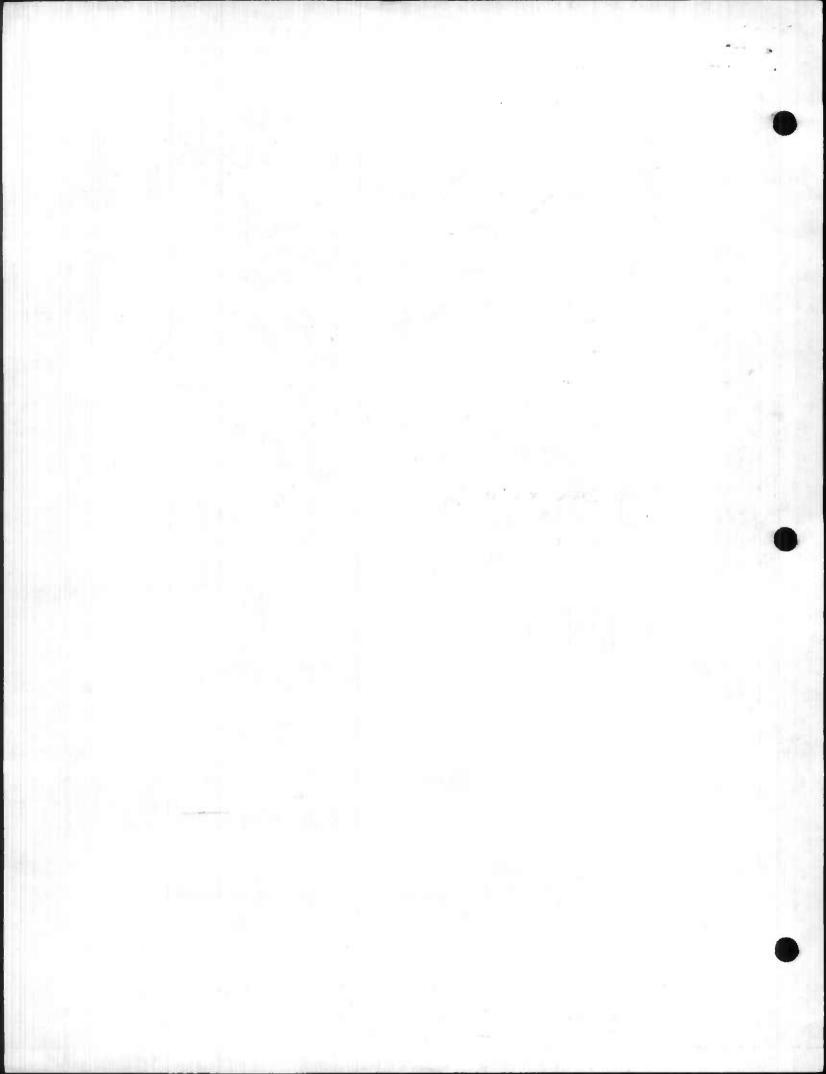
I Medical Examiner: On the basis of examination and/or investigation, in my opinion, daeth occurred at the time, dete end place, and due to the cause(s) and manner stated.

29c. Licensa number

Hoffman

D0053612

29d. Data signed (Month, Day, Year)



Baltimore, Maryland 21215-0020

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amend Item # 8,2/2/2000, per FH, G780, gap 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month Dev **Physician** RUTH L. GALE 2000 JANUARY 26, 0550 AM /Medical 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner 4908 CORDELIA AVENUE BALTIMORE N A If Under 1 Yeer | If Under 24 Hrs. 8. Defe of Birth 3/3/41 (Month, Dey, Year) Birthplece (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. lest birthday) **Funeral** 10 M 20 F Months Deys Hours Min C20-36-2089 Usuel Residence of Decedent 58 Yrs. Director 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-t show the Medical Examiner must be notified at 1 Ves 2 No BALTIMORE NI MD Directo 10e. Streef and Number 10g. Citizen of What Country? 10f. Zip Code "natural", or items 23s 4908 CORDELIA 21215 VENUE Funeral Wes Decedent Ever in U.S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Rece - American Indian, Bleck, White, etc. 11. Meritel Stetus filed within 72 hours after 1 Yes 2 No If Yes, Give Yeer or Detes: 1 ☐ Never Merried 2 ☐ Merried Specify: BLACK 1 ☐ Yes 2 ☑ No Specify: þ 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) 38ISTANT 12 TH GRADE NIA WRSING ARF EALTH 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) Be nit. Pages 1 and 2 should be artment of Health and Mental ortant: If Nem 27 is marked o MORROW FREEMAN LOTH 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) HENDERSON SISTER BALTO ELAINE 4607 BELVIEU AVE. mo. 20b. Pleca of Disposition (Neme of cemetery, crematory or other piece) 20e. Method of Disposition 20c. Location - City or Town, Stete Dete Pages ment of 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete 2-1-2000 BALTO MO 4 ☐ Donetion 5 ☐ Other (Specify) WOODLAWN CEMETERY 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility VAUGHN C. GREBUE FUNERAL SERVICE 5151 BALTO NATU PIKE, BALTO MO 21229 aus Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Physician /Medical Immediate Cause (Finel Cardiovascular Diseas Atheroselerone disease or condition resulting in deeth) **Examiner** Due to (or as e consequence of) Examiner The law requires that the deeth certificate be executed burial-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in deeth) Last Due to (or es e consequence of). attending physician and Physician/Medical Due to (or es e consequence of) Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? detached 1 Yee 2 No 3 Probably 4 McOnknown abefes mellitus by F 24b. Were autopsy tindings evailable prior to completion of cause of death? 24a. Was an autopsy Completed performed? Choression page 2 1 Yes 2 □ No 1 Yes 2□ No certificate 25. Wes case referred to medical examiner? Be 26. Piece of Death (Check only one) Hospitel: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Desidence 6 □Other (Specify) Yes 2□ No 2 27. Menner of Death 28b. Time of

Division of Vital Records, P.O. Box 68760, or Attanding Physician: is effer death.

al Director: After this or Certification:

28d. Describe how injury occurred 28a. Dete of Injury (Month, Day Year) 28c. Injury af Work? 1 Neturel
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 | Homicide

29a. Certifier (Check only one)

edical

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and plece, and due to the cause(s) and manner as stated 25 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end placa, end due to the cause(s) end manner steted.

29b. Signature end title of certifier

29c. License number O.C.M.E. 29d. Dete signed (Month, Day, Year) JANUARY 26, 2000

30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print)

120

111 Penn Street, Baltimore, Maryland 21201 huten enni 32 Registrer's Soneture

bute so

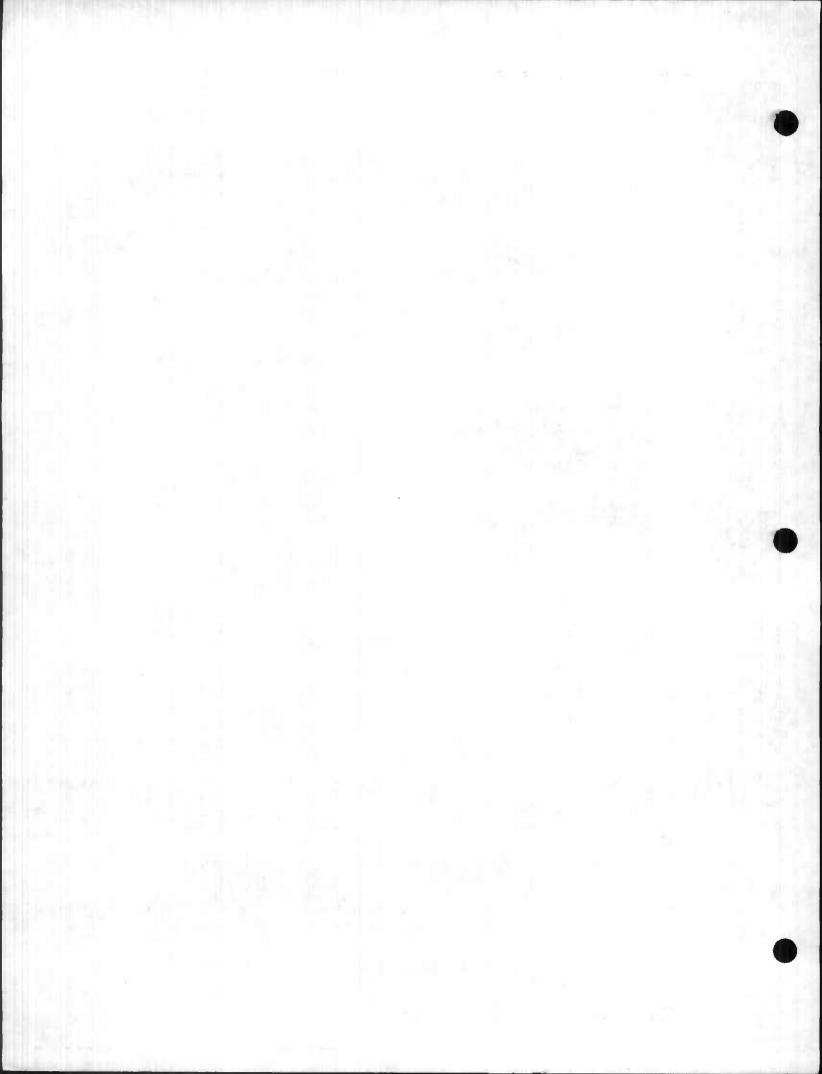
State

31. Dete filed (Month, Day, Year) FEB 0 1 2000 Registrar

within 24 hours To the Funeral I

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completely

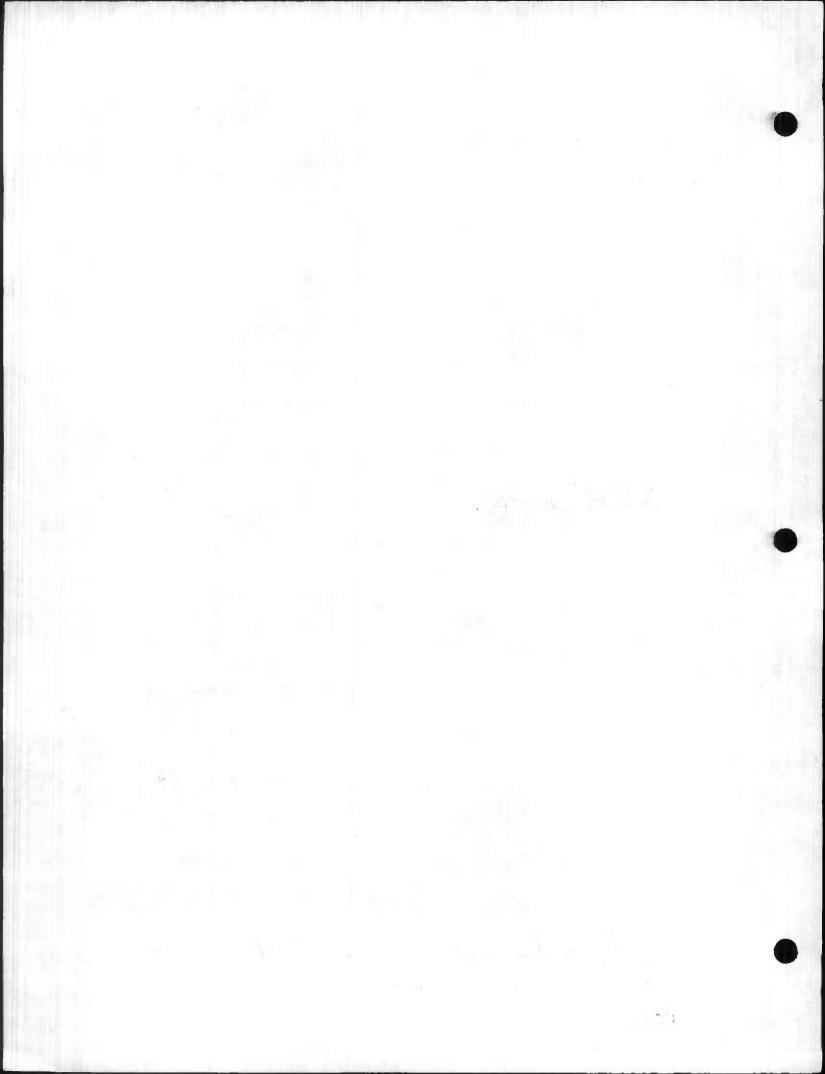


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State of Maryland / Department of Health and Mental Hygiene O O

| hysician | Decedent's Neme (First, Middle, I | .ast) | | 45 | | Limit | 2. Date of Do Month | Reg. No. seth Day | Year | Time of Death | |
|------------------|---|--|---|---|--|--|---|---------------------------------|--|---|--|
| ledical | Jacob F. Gauss | | | | | | Januar | | | 2:25 A.M | |
| miner | 4a Facility Nama (If not institution, g VACHCS FORT HOW | | | | | 4b. City, Town, or I | | | y of Death IMORE | | |
| | | | nga (In yrs. last | | er 1 Year Days | If Under 24 Hrs. | | rth ay, Year) | | (State or Foreign | |
| | Usual Rasidance of Dacedant 10a. State 10b. County | | 10c City T | own or Location | | | | | 10d b | nside City Limits | |
| to | MD N/A | | 100. 04, 1 | Balti | morre (| City | | | | 13 yes 2 □ No | |
| i Director | 10e. Street and Number 1628 Webster Street | | 100 | 101. 2 | ip Code | 21230 | | - | What Country? ed States | | |
| by Funeral | 11. Merital Status 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. Was Deceden Armed Forcas NN Yes 2 ☐ If Yas, Giva Yaar or Dates | ⁷ Marine Corps | | edent of lecify Cub | Hispanic Origin? (S ean, Mexican, Puerl Specify: | pecify Yes or No Rican, etc.) | o- 14. Ra Bla Specii | ce - American fr ick, Whita, etc. by: Whit | | |
| Completed | 15. Decedant's (Specify only highest g Elamantary/Secondary (0-12) | Education rade completed) Collega (1-4or | 1 5+) | | Usual Occupation of work done during most of working OT use retired) 16b. Kind of Business/Industry Industry I | | | | | | |
| Be Co | 17. Father's Nama (First, Middle, La | | | FOLI | Janan | 18. Mother's Nar | ne (First, Middle | | | C | |
| ToB | Jacob F. Gauss | | | | | | Helen Wheeler | | | | |
| 1000 | 19a. Informant's Name/Ralationship Catherine Alder / | | 1 | | | | Jural Route Number, City or Town, State, Zip Code) Linthicum Maryland 21090 | | | | |
| | 20a. Mathod of Disposition 1 ⊠ Burial 2 ☐ Cremetion 3 4 ☐ Donation 5 ☐ Other (Spec | | ceme | of Disposition (Netery, cremetory of SVIIIe Veta | other pla | ce) Cem. Janua | Date ary 28, 2 | | - City or Town, S SVILLE MA | | |
| *SUG | 12. Burial 2 Crownsville Veterans Cam. January 28, 2000 Crownsville Maryland 4 Donation 5 Other (Specify) 1. Signatura of Funaral Service Licensee Victor P. Doda, Jr. Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore Maryland 21230 3a. Part I. Entar tha diseasa, or complications that caused the death. Do not entar the mode of dying, such as cardiac or respiratory arrest, Interval Between | | | | | | | | | | |
| edicai Examiner | Immediate Causa (Final disease or condition rasulting in death) Sequentially list conditions, if any, laeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated evants rasulting in death) Last | a. EMPHYS b. PNEUMO c. | Dua to (or as Dua to (or as | S LYMPHO a consequence of a consequence of |):): | | | | | | |
| by Physician/Mec | | d | | | | | | | | | |
| Physi | Pert II. Other significant conditions | contributing to death | tributing to death but not resulting in the underlying cause given in Part I. | | | | | Yes 2 No | 3 Probably | cause of death? | |
| Completed by | | | | | | | | s an autopsy omed? | availab | outopsy findings le prior to ition of cause h? | |
| mo: | | | | | | | 10 | Yes 2 KNo | | s 2 No | |
| Be | 25. Was casa rafarred to medical axaminar? | | | | , | 26. Place of Dea | nth (Check only | one) | | | |
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| Medical Certifi | 29e. Cartifiar (Check only one) | thyelclan: To the best miner: On the basis of and manner s | of axamination | dge, death occurre and/or investigation | d at the ti | ima, data and place opinion, death occu | , and due to the rred at the time | cause(s) and m | nanner as stated , and due to the | l. cause(s) | |
| Z | 29b. Signature and title of certifier | 1 | | 2 | 9c. Licen | se number | | 29d. Date sign | ed (Month, Day, | Year) | |
| | 30. Name and address of person on | complated causa of | death (Item 23 | a) (Type, Print) | 25 | 0454 | | Jan. | ,22) | 2000 | |
| State | ARASTOO VAZIDANT 31. Date filed (Month, Day, Year) | M.D. 96 | | H POINT | BUFD | , FOPT HO | WARD, N | D 21052 | | | |

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death GRABOSKI JANUARY TWENTY 2000 **Physician** CLARA 4.28 AM /Medical 4a. Fecility Name (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** GOOD SAMARITAN HOSPITAL H Under 1 Year | If Under 24 Hrs. | 8 Date of Bird 5. Social Security Number 7. Age (In yrs. last birthdey) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) Months Days 1□ M 25 F Hours 79 Yrs. Director 220-18-8368 8/22/20 PENNSYLVANIA Usual Residence of Decedent with the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits ahow traumetic event, the Medical Examiner must be notified at Director 1 Yes 2 □ No 288-4 MD N/A BALTIMORE CITY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 238 1264 MERIDENE DRIVE USA 21239 Funeral Herne 12. Was Decedent Ever In U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be filled within 72 hours effer nent of Health and Mentai Hygiene. Intern 27 la marked other than "natural", or its 1 ☐ Yes 2 ☐ No If Yes, Give Year or Detes: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: þ 3 Widowed 4 Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) **ASSEMBLY** SCIENTIFIC RESEARCH 12TH GRADE 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Malden Surname) Be 70 DEMETER GLAGOLA SOPHIA UNAVAILABLE 19e. tnformant's Name/Reletionship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 end 2 s Department of Health ar Important: If item 27 ia any injury or other trau 2002. JOHN J. GRABOSKI HUSBAND 1264 MERIDENE DRIVE BALTIMORE, MD 21239 20b. Pleca of Disposition (Name of cemetery, crematory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Surial 2 Cremetion 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) PARKWOOD CEMETERY 1/29/2000 BALTIMORE, MD 21. Signeture of Funeral Service Licenses 22. Name and Address of Facility THE JOHNSON FUENRAL HOME, P.A. eyor complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest.

MD

TOWSON, MD 21286 Approximete 23a. Part1. Enter the disease, shock, or heart failure. rvsl Bet Onset end Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) SEPSIS FOUR DAYS Examiner Due to (or as a consequenca of): Examiner SCHEMIL BOWEL The law requires that the death certificate be executed physician and the burial-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Lest Due to (or as a consequence of): Box 68760. CARDIOMYOPATHY SCHEMIC Physician/Medical Due to (or as a consequence of): attending p P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 5 1 Yes 2 No 3 Probably 4 Unknown been signed be should be det Records, É 24b. Were sutopsy findings eveilable prior to completion of cause of death? Completed 24a. Was an autopsy performed? page 2 : certificate 1 Yes 2 M No 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attending Physician: director. 25. Was case referred to medical Be 26. Place of Deeth (Check only one) Hospitai: Other: 4 ☐ Nursing Home 5 ☐ Residenca 6 ☐ Other (Specify) Certification: To 1 ☐ Yes 2 No 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural 5 Pending Investigation death. 1 Yes 2 No d in by the f 2 Accident 3 Sulcide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) after 4 Homicide within 24 hours a
To the Funeral C
completely filled edical 1 Certifying Physicisn: To the best of my knowledge, deeth occurred et the time, date and plece, end due to the cause(s) and menner ss ststed.

2 Medical Examiner: On the bests of examinetion end/or investigetion, in my opinion, death occurred et the time, dete and plece, and due to the cause(s) and manner ststed. 29a, Certifier (Check only one) the 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) Dominique Mall, M.D. P 13455 1/26/2000 GOOD SAMARITAN 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) DOMINIQUE MALL

State Registrar 31. Date filed (Month, Day, Year) FEB 0 1 2000

LOCH

RAVEN

5 601

32. Registrar's Signeture

BOULEVARD

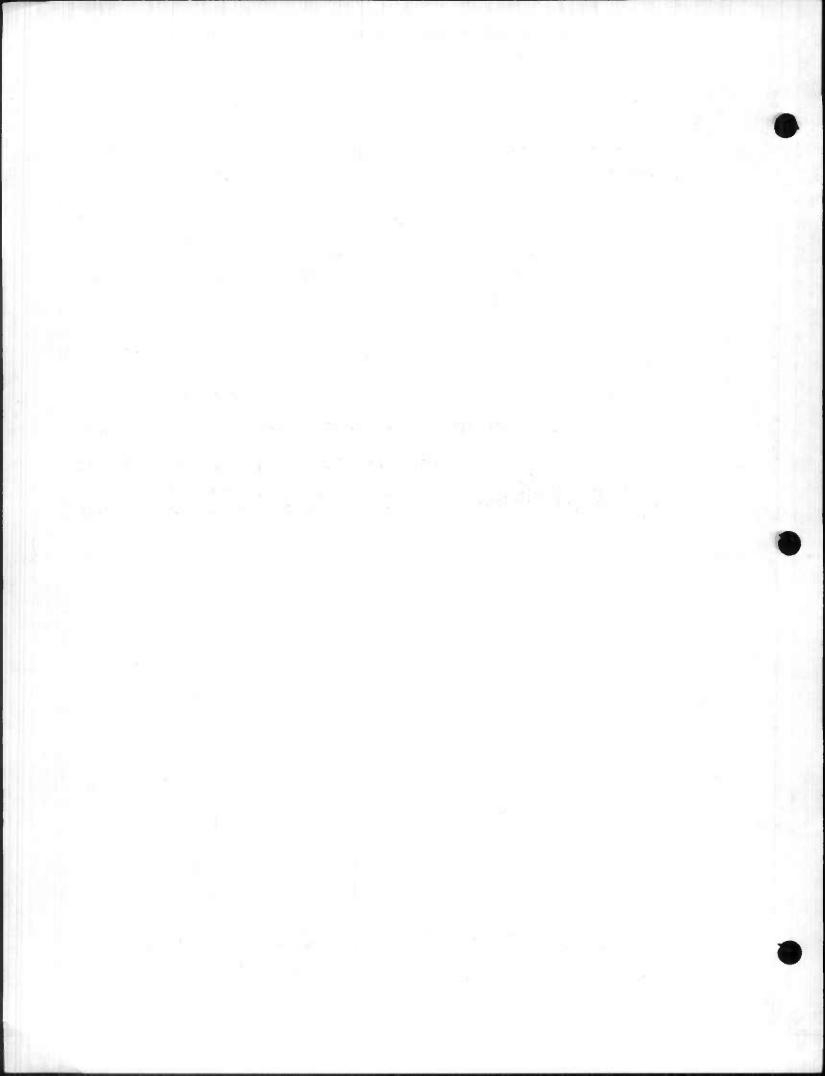
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BALTIMORE

M. D.

21239

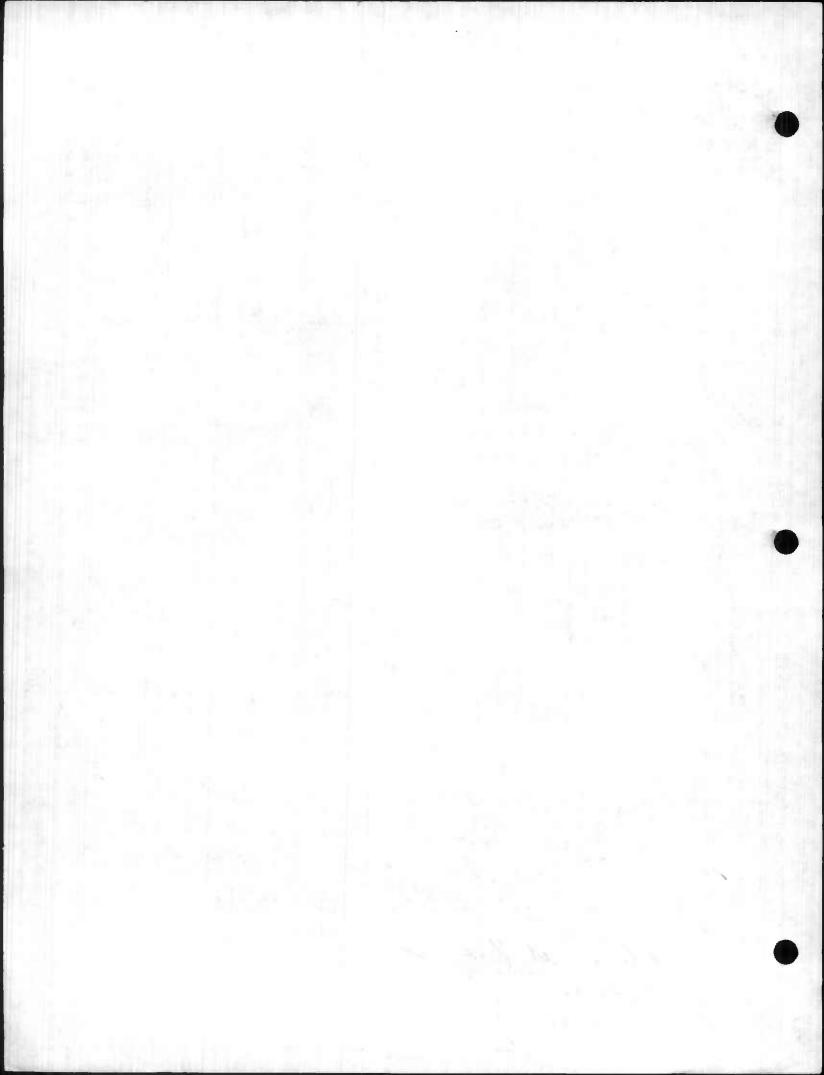
DHMH 16 Rsv 6/95



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| al or | | Sociel Security N 578–76– | 5982 | 6. Ser | x M 2□ F | | (In yrs. li | ast birthday, Yrs. | Months | Deys | If Under Hours | 24 Hrs. Min. | 8. Dete of (Month Aug. | Birth Day Y | (ear) 1953 | 9. Birth Cou Ma | place (State or intry) ryland |
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| Funeral | | 9720 Con | ımar Ko | | | | | | | 220 | | | | | .S.A. | | in a ladian |
| Dy ruite | | 11. Meritel Stetus 1 Never Merried 2 Married 1 Never Merried 2 Married 3 Widowed 4 Divorced 12. Wes Decedent Ever in Armed Forces? 1 Never Merried 2 Never or Detes: | | | | | | 13. Wes Decedent of Hispanic Origin? (Specify Yes If Yes, specify Cuben, Mexicen, Puerto Rican, e 1 □ Yes 2 ☑ No Specify: | | | | | ecify Yes of Rican, etc. | No- | | ck, White | ican Indian, , etc. ite |
| | | 3 11 11 10 N 10 1 | 15. Deceden | | | Deles. | | 16a. Dece | dent's Usu | el Occup | ation | | | 16 | Sb. Kind of B | | |
| Auch se best within 72 hours also Mental Hygiene. **Mental Hygiene. **And other than "natural", or it also event, the Medical Examin to the Completed by Fu | | (Specification) | cify only highe | st grade | e complete | ed) e (1-4or 5+ | ·) | - | ta. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) Security Guard Agacus Se | | | | | s Sec | curity | | |
| | | Father's Neme James P | | | aham, III | | | | | 18. Mother's Neme (First, Mi Stephanie M | | | | | | ne) | |
| | 1 . | e. Informent's No | | | rpe, Print) | | | 19b. Mell | ing Address | s (Street | en <i>d Numb</i> | er or Rur | el Route Nu | m <i>ber</i> , C | City or Town, | State, Z. | ip Code) |
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death GENEVIEVE 2000 4e. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death BALTIMORE SECOURS HOSPITAL 7. Age (In yrs. last birthday) If Under 1 Yeer If Under 24 Hrs. Hours Min. 5. Sociel Security Number Birthplace (State or Foreign Country) Months Days 10M 20F 212-30-5953 Marylons DEC 10, 1908 Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits Jeres 2□No BAIFINOTE Mary/mo 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? CALHOUN Street US17 205 N. 2/1/7 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ♣ No If Yes, Give Yeer or Dates: Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, Bleck, White, etc. 11. Meritel Status 1 Never Married 2 Married 1 Yes 2 No Specify: Block 3 Widowed 4 □ Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Baltimore Oty Elementary/Secondery (0-12) College (1-4or 5+) TEACHER SCHOOLS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) JOSEPH DOTSCH LOUISE 19e. informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 3 1217 Granory 705 n. CALHOUN STREET LEGABRO MCKNIGHT BoltionerE, Marysas 20b. Place of Disposition (Neme of cemetery, creme tory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date Pikesvills, narylons 2-2-2100 Burial 2 Cremation 3 Removal from State Redge ameter 2 -2 200 Pikes VIIIs, Mary 22. Name and Address of Facility CHA-TMAN - HARRI FUNCH HUME 4 □ Donetion 5 □ Other (Specify) 21. Signature of Funeral Service Licensee BAHIHOR MISTONER KOMS BAHIMOR 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in deeth) PREUMONIA CARDIOVASCULAR DISEASE Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last ARR HYTHMIA 23b. Did tobacco use contribute to the cause of deeth? GASTRO INTESTINAL 3 Probably 4 Uhknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings eveilable prior to completion of cause of death? 24a. Was en eutopsy performed? SEPSIS

Physician /Medical Examiner

permit. Page Department of Important: If any Injury or once.

Physician

/Medical

Examiner

Funeral

Director

"natural", or items 23s or 28s-f show

h and Mental Hygiene.
7 is marked other than "natur traumatic event, on Medical

Pages 1 and 2 should be filed within 7 nent of Haalth and Mental Hygiene. nnt: If Itam 27 is marked other than "r ury or other traumatic event, in a least

21215-0020

Baltimore, Maryland

Box 68760.

P.O. I

Records,

Division of Vital or Attanding Physician: Director

Completed by Funeral

Physician/Medical þ Completed

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 60 page 2 should 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 1□ Yes 2□ No Certification: To 2 ER/Outpatient 3 DOA 27. Menner of Deeth 28b. Time of 28c. injury et Work? After 1 Maturai 5 Pending investigation death. 1 Yes 2 No To the Hospital or Attandl within 24 hours after death. To the Funeral Director; A 2 Accident filled in by the 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical 29a, Certifier completaly (Check only one) 29b. Signature end title of certifier 29c. License number

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred Location (Street and Number or Rural Route Number, City or Town, Stete) 1 Certifying Phyelcian: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, end due to the cause(s) and manner stated.

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

26

1 ☐ Yes 2 ☐ No

KOSITA

BON SECOURS

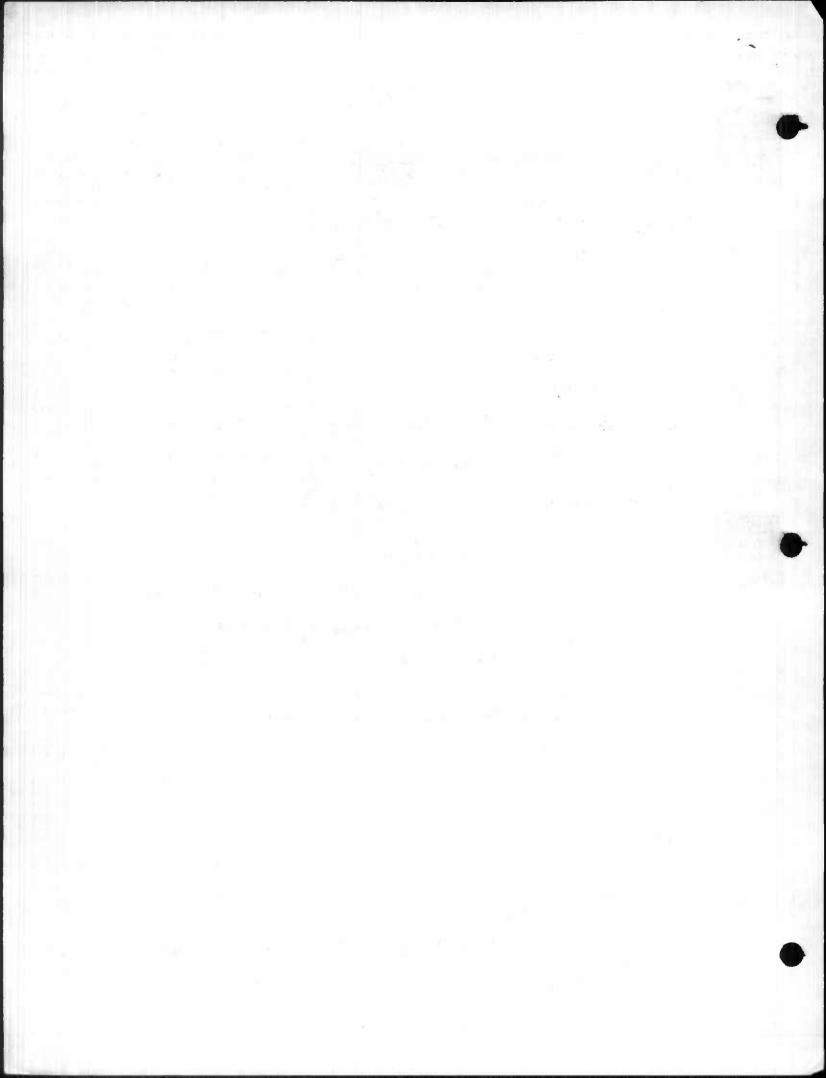
1 Yes 2 No

State Registrar

31. Dete filed (Month, Day, Year)

FEB 0 1 2000

32. Registrar's Signature



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** ALFred Hopkins KENNETH 2000 Januari 26 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner J Maryand Hediane 7. Age (In yis last birthday) BALTIMUR Deaton University 5. Social Security Number 6. Sex If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthpleca (Stata or Foreign Country) If Under 1 Year 1 M 2□ F **Funeral** Deys Months 48 217-52 - 922) Usuel Residence of Decadent Director Marylmo 10c. City, Town or Location 10a. Stete 10b. County 10d. Inside City Limits item 27 is marked other than "natural", or itema 23a or 28a-1 show other traumatic event, the Nedical Examiner must be notified at Yes 2 No BALTIMORE Director Navy han 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2718 Jallerson USM 21205 Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑10 If Yes, Give Yeer or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: Black py 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Balhaur Elementary/Secondary (0-12) College (1-4or 5+) LABOTEY CUSEYR HEIVE grade 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Peges 1 and 2 should be f Department of Health end Mentel I Important: If item 27 Is marked of VIRGINIA CArke Hopkins ARTHUR Jom Es 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Street Baltitiers, Rel 21205 TAMES HEPKINI 2718 Jellerson BrETHER 20e. Method of Disposition 20b. Plece of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removel from State 1-31-2010 any injury or HUBUTUI 4 ☐ Donation 5 ☐ Other (Specify) MEMERIAL Tay/c 22. Name and Address of Facility CIAA THAM - HARRIS ROCIEL HO. N.C. 21. Signeture of Funeral Servica Licensee 5240 RUSTERSTURE MAIN 23a. Pert1. Enter the disease or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Deeth **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequenca ot): Examiner reed Cences Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequenca of) bunial-tran and physician the thial Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): 80 9SD Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Anemia þ 24b. Were autopsy findings eveileble prior to completion of cause of death? 24a. Was en autopsy Completed Hepelis, Kirch performed? 2E No 1 ☐ Yes 2 ☐ No 1 T Yes certificate Division of Vital Hospital or Attending Physician: 25. Was case reterred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Nursing Home 5 Residence 6 Other (Specify) 1□ Yes 2□ No 10 After this funeral 28a. Dete of Injury (Month, Day Year) 28c. Injury et Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 24 hours efter deeth. 1 ☐ Yes 2 Accident 6 ☐ Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Placa of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 12 Certifying Phyelclan: To the best of my knowledge, death occurred et the time, dete and plece, end due to the ceuse(s) and menner es steted. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date and placa, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the I 29d. Dete signed (Month, Day, Year) 29c. License number 29b. Signature end title of cartifier

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Registrar

31. Date filed (Month, Day, Year)

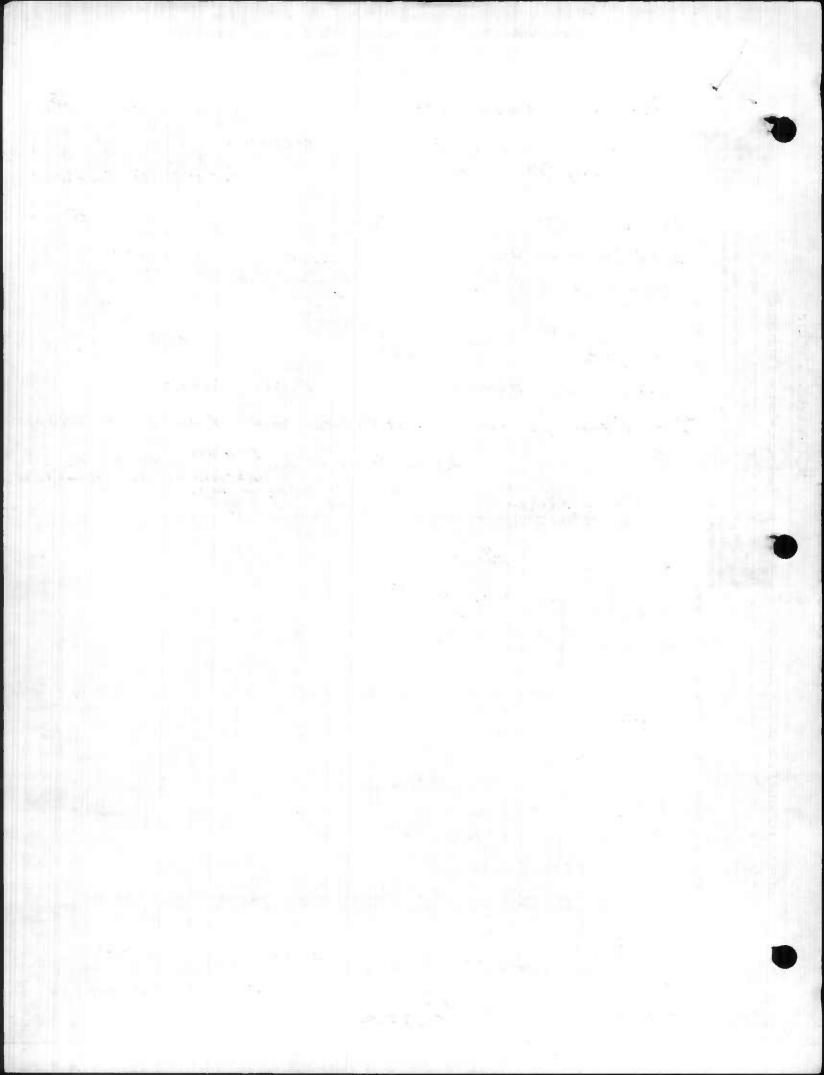
1147 50-12 352 MJ 32. Registrer's Signature

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

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DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 24 2000 Doris Harrison Jan. Ann 7:20 P.M. 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore 9029 Allenswood Road 5. Social Security Number 6. Sex Randallstown If Under 1 Year 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (Stata or Foreign Country) Months Hours Min. Deys 1 M 200 217-05-6149 June 19, 1920 | Maryland Usual Residence of Decede 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yas 2√ No Baltimore Randallstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9029 Allenswood Road 21133 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ②☐No If Yes, Give Year or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, atc. 11. Marital Status 1 Never Married 2 Married 1 Yes 2₺ No Specify: Specify: White 3 X Widowed 4 □ Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Home Homemaker 12 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Maude Grimm Alfred S. Neely 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah Pritchett 2217 Cape Horn North, Hampstead, MD 21784 20a. Mathod of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lake View Memorial Park 1/28/00 Sykesville, MD 21. Signature of Funeral Service Licensee 22. Nama and Address of Facility Loring Byers Funeral Directors 8728 Liberty Road, Randallstown, MD 21133 ellen M00 333 Intl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest nock, or heart failure. List only one cause on each line. Approximate terval Bety Onset and Death Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Ware autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No 25. Was case reterred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manger of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 D Homicide

that the death certificate be executed physician as the bunal Box 68760, for use signed by the ai The law requires page 2 s Hospital or Attending Physician: this funeral After after death. Director: Aft 2 filled in

Examiner Physician/Medical ò Completed Be Certification: To

Physician

/Medical

Examiner

Director MD

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Health and Mental Hygi em 27 is marked other

Department of Health a important: If Item 27 is any injury or other tra

Physician /Medical

Examiner

Pages 1 and 2 should be

the Maryland r 28a-f show notified at

72 hours after

Baltimore, Maryland 21215-0020

P.0. Records. Division of Vital

To the Mospital or within 24 hours at To the Funeral D completely filled i

DHMH 16 Rev 6/95

State Registrar

Medical

31. Date filed (Month, Day, Year) 0 1 2000 FEB

29a. Certifier

29b. Signature

(Check only one)

30. Nama and address of per

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on who completed cause of death (Nery 2pg) (Type, Print) POREZ MERA 45 TERSTOWN

29c. License number 10613

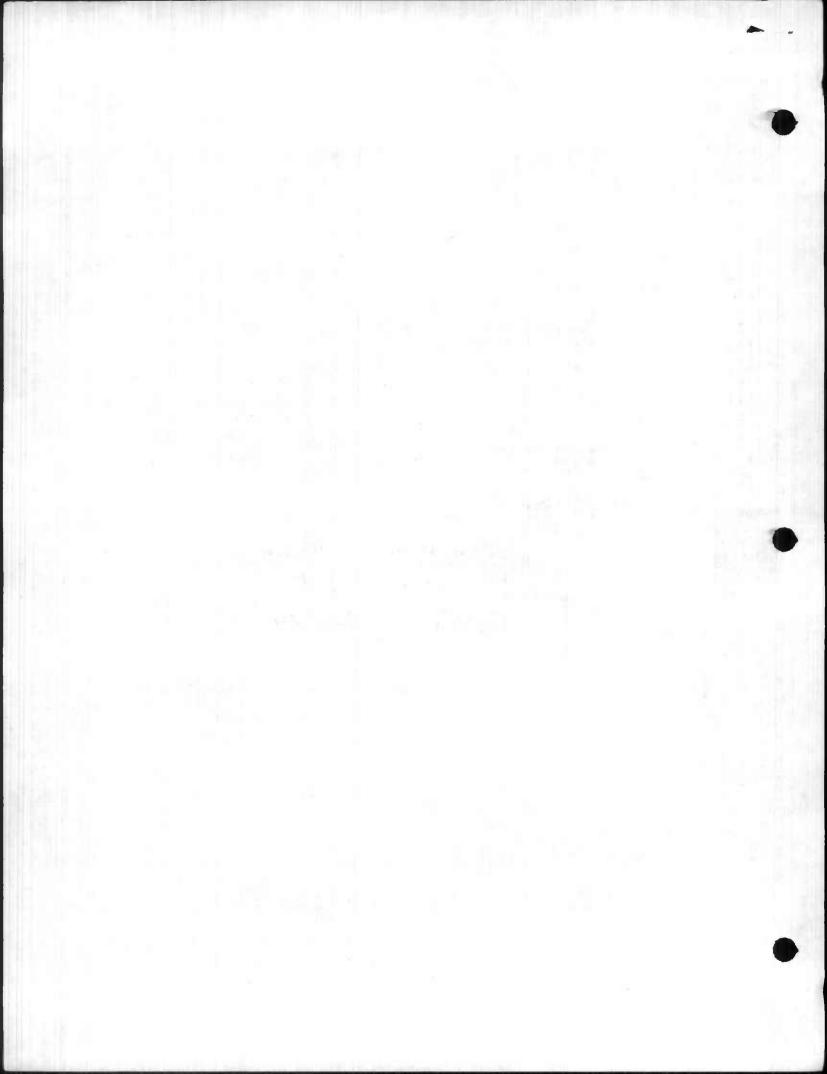
18 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year) 1-26-2000

32. Registrar's Signature Denew

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Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

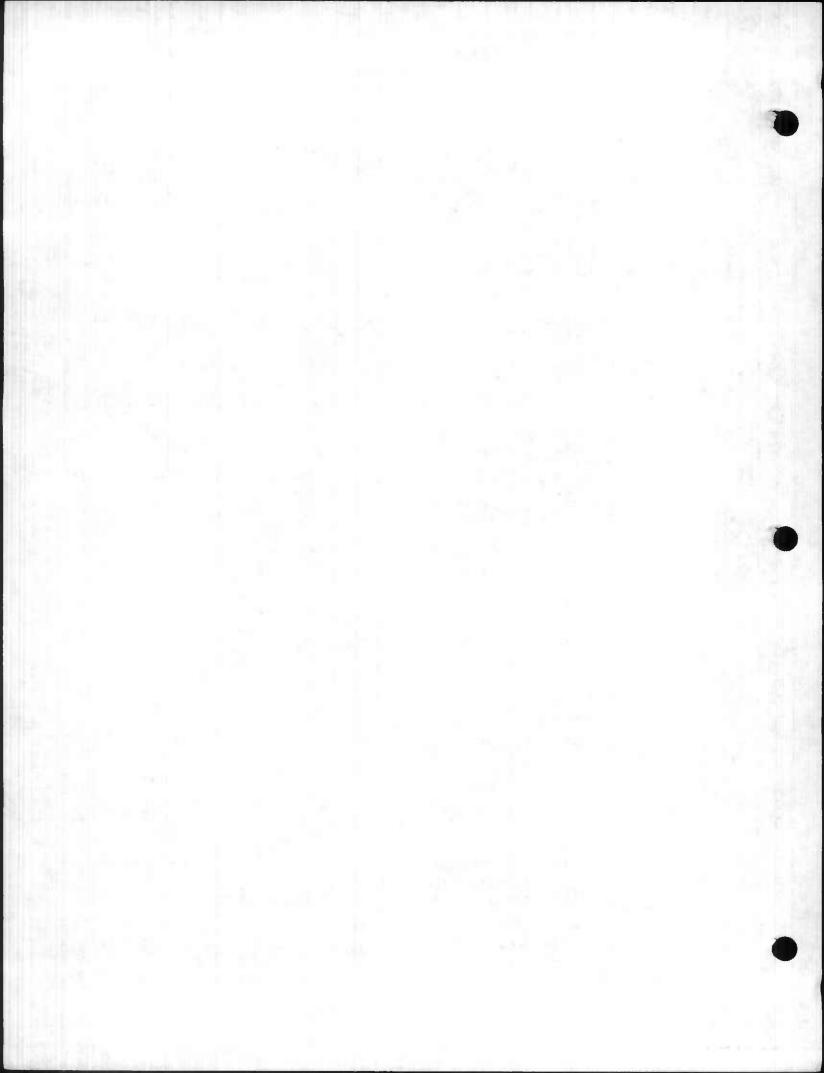
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| AI | VIN J. | HOWARI |) | | | | Certi | ficate of | f Death | 7 | | Reg. No. | 0 | 26430 |
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| | | | dent's Name (First, Midd | fle, Last) | | | - | | | | 2. Date of Dea | | Year | 3. Time of Death |
| ga. | Physiciai /Medica | | ALVIN HOWAR | SD CD | | | | | | | JANUAR | | | 1514 PM |
| ř | Examine | 4a Facil | ity Name (If not institution | | ium <i>ber)</i> | | | | | | cation of Death | | | |
| | | 00 |)1 EAST 21S | | | | | | a market | 'IMOR | | | N/A | |
| | Funeral Director | unk | Security Number | 6. Sex 1 → M 2 → F | 7. Age (In | yrs. last b | | If Under 1 Year Months Day | | | 8. Date of Birt (Month, De) Sept 21 | | | place (State or Foreign htry) NOWN |
| | P | 10a. Sta | esidence of Decedent te 10b. County | у | 100 | . City, To | wn or Locat | tion | | | | 1100 | | 10d. Inside City Limits |
| | Maryl A | M | D | N/A | Ba | ltim | ore | | | | | | | 1 Yes 2 No |
| | r 28s | 10e. Str. 25 | set and Number | | | | | 10f. Zip Code | | | | 10g. Citizen of | Whet Cou | ntry? |
| | 38 o | 25 | 17 Brookfie | 1d Avenue | | | | | 212 | 217 | | USA | | |
| | dead dead | 11. Mari | tal Status unknow | t2. Was De | cedent Ever Forces? | in U,S. | 13. Wa | s Decedent of | | | ecify Yes or No- Rican, etc.) | | | can indian, |
| Maryland 21215-0020 | urs e | 3 🗆 | Never Married 2☐ Mai Widowed 4☐ Divorce | rried 1 Yes | 2 No Sive UNK | own | | Yes 210 N | | | , 102-1, 010-1, | Specif | | black |
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| and | Mental P Mental P arked of | 17. Faul | er's Name (First, Middle | , Last) | | | | | 18. MOII | | | | 110/ | |
| 2 | should be nd Mental marked o umatic sv | 10e Inf | unknown ormant'a Name/Relation | ehin (Tune Print) | | 10 | h Mailing | Address (Stre | et end Numi | | unknown | er, City or Town | State 7i | Code) |
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| ē, | f Health if Health them 27 other tr | - | thod of Disposition | | 20 | 0b. Place | of Dispositi | ion (Neme of | | | Date | 20c. Location | | own, State |
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| | | - 23a. Pa | of 1. Enter the disease, d ock, or heart failure. Lis | r complications that | caused the | death. Do | | | | s cardiac o | or respiratory as | rest, | 1 | Approximate |
| Š | Physician | sn | OCK, or heart failure. Lis | t only one cause or | each line. | | | | | | | | | Onset and Death |
| 9 | /Medical | Immedi | ate Cause (Finel or condition | STAB | WOUND | S OF | CHEST | T AND I | RIGHT | ARM | | | 24 | |
| 6 5 | Examiner | resulting | g in death) | a | | | conseque | | | | | | - 1 | |
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| | cate be executed physician and s the bunal-transit | Sequen | tially list conditions, | 0. | Due | to (or as a | conseque | ince of): | 799 L | | | | | |
| Ď, | olan clan d | cause. | tially list conditions, seding to immediate Enter Underlying Disease or Injury | | | | | | | | | | | |
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| 5 | res that the de signed by the s i be detached i | Pert It. C | Other algnificant conditi | lona contributing to | deeth but no | resulting | in the unde | erlying ceuse | given in Pari | H. | | Yea 2 No | | to the cause of death |
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| ecords, | law requires that the as been signed by the 2 should be detached. | 3 | | | | | | | | | | an autopsy | | ere autopsy findings |
| 000 | s bee | | | | | | | | _ | | perio | rmed? | 0 | ompletion of cause death? |
| I | Physician: The lav this certificate has al director, page 2 | | | | | | | | | | 1 🔯 | Kes 2□No | 1 | XIXes 2□ No |
| | entifical sctor, p | 25. Was | case referred to medica | al | | | | | 26. Plac | ce of Deat | h (Check only o | | 1 | |
| > | Physician: this certific rai director, | | niner? Yes 2∐ No | Hospitel: | Inpatient | 2 🗆 ER/C | Dutpatient | 3 DOA | Other: 4 1 | Nursing Ho | me 5 Resid | dence 6 88t | her (Speci | y) SCENE |
| on of | Attending Ph or death. ector: After th by the funeral | | ner of Death Natural 5 Pendi Accident Invest | ing 28a. Dat | e of Injury onth, Dey Yes 2000 | 28b. | Time of Injury | 28c. In W | jury at /ork? ☐ Yes 2 [| | 28d. Describe SUBJEC | T WAS | rred STABB | ED |
| Division | tal or Attending P rs after death. al Director: After t led in by the funers | 湿 | Suicide 6 Could | not be mined 28e. Pie buil | ce of Injury - iding, etc. (Sa GAS S. | At home, pecify) | ferm, street | erm, street, factory, office 28f. Local City | | | | ation (Street end Number or Rural Route Number, or Town, Stete) CHARLES AND 21st BALTO. ,MD | | |
| | To the Hospital or I within 24 hours after To the Funeral Dire completely filled in E | | | ng Physician I Examiner, On the | le best of my | knowledg | ge, deeth o | ccurred et the stigation, in my | time, date e y opinion, de | and place, eath occurr | and due to the | cause(s) and m | anner es | stated. to the cause(s) |
| | o the | - | nature and title of certific | 111 | 7.00. | | | 29c. Lice | nse number | | | 29d. Date sign | | |
| | - > - 0 | - | | 1/4 | / | | | 0. | C.M.E | • | | JANUA | RY 4, | 2000 |
| | | 30. Nam | e and address of persor | who completed ca | use of death | (Item 23a |) (Type, Pri | int) | 0 6 1 1 | | | | | |
| | | JO | SEPH PESTAN | ER, M.D. | 111 | Penn | Stre | eet, Ba | ltimo | re, M | laryland | 21201 | | |
| | | 21 Date | filed (Month, Day, Year | 1 30 | Registrar's S | ioneture | | , | | | | | | |

Registrar

FEB 012000 Service



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 3. Time of Death 2. Data of Death Month Day Year JANUARY 29,2000 **Physician** 3:15 AM Wilma B. Howard /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Oakcrest Care Center Baltimore If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Yaar 8. Data of Birth
(Month, Day Year) 9. Birthplace (State or Foreign **Funeral** Days Months 10 M 20 F Hours North Carolina 86 Director 237-03-0140 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Parkville Maryland Baltimore 1 ☐ Yes 2 ☑ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ð U. S. A. 21234 8830 Walther Blvd. Unit #211 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14 Race - American Indian 11. Merital Status Bleck, White, etc. 1 ☐ Yas 2/☐XNo If Yes, Giva Year or Dates: 1 ☐ Nevar Married 2 ☐ Married natural, or 1 Yas 2 No Specify: White 3 ₩idowed 4 Divorced 16a. Decedent's Usuat Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Real Estate Sales Agent 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Meiden Sumeme) Be Pages 1 and 2 should be Health and Mental Priscilla Boyce Benjamin 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) 11 Little Plains Court, Huntington, New York 11743 Mr. Clark E. Howard (Son) reportant: If Item 27 Baltimore, 20a. Mathod of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) Data 20c. Location - City or Town, Stata 8 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Stata Pikesville, Maryland 2-2-00 Druid Ridge Cemetery 4 Donation 5 Other (Specify) 21. Signature of Funaral Sarvice Licensee 22. Nama and Addrass of Facility Ruck Towson Funeral Home, Inc. Wallace S Brooker 1050 York Road, Towson, Md. 21204 23a. Pert1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such es cardiac or raspiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediata Causa (Final neumonia 1day diseasa or condition rasulting in death) Examiner Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events rasulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical Due to (or as a consequence of): the Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown ementia Records, by 24b. Were autopsy findings evailable prior to completion of cause of death? 24a. Was an autopsy performed? Completed Coronary Artery Disease 1 Yes 2 VI No 1 ☐ Yas 2 ☐ No Division of Vital or Attending Physician: 25. Was case reterred to medicat examiner? Be 26. Place of Deeth (Check only one) Hospital: Other: Nursing Home 5 Residence 8 Other (Specify) 1 Yes 25 No Medical Certification: To 1 | Inpatient 2 | ER/Outpatient 3 | DOA this 27. Mannar of Death 28a. Dete of trijury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After Natural 5 Pending death. 1 ☐ Yas 2 ☐ No To the Hospital or Attenditional within 24 hours after death.

To the Funeral Director: A completely filled in by the fu invastigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28a. Place of tnjury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homlcide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and dua to tha cause(s) and mannar as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and dua to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature end titla of certifier 29c. License number 29d. Data signed (Month, Day, Year) 30. Nama and address of person who completed cause of death (ttem 23a) (Type, Print)

Registrar DHMH 16 Ray 6/95

WILLIAM RUSSELL

FEB 0 1 2000

31. Data filed (Month, Dey, Year)

Douks

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32. Registrar's Signatura

BALTIMIE MD

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| r | Physician /Medical | 1. Decedent's Name (First, Middle, ROBERT JAME | S HICKS | | | | | 2. Date of D Month | y ZL | Year 2000 0520 | | |
| | Examiner | 4a Facility Name (If not institution, | | ımber) | | | | or Location of Dea | th 4c. County | of Death | | |
| | | | PITAL 6. Sex | 7. Age (In yrs. | last hirthday) | If Under 1 Yea | | rs. 8. Dete of B | irth | 9. Birthplace (State or Foreign | | |
| L | Funeral Director | 246-48-7209 Usual Residence of Decedent | 10 X M 2□F | 68 | Yrs. | Months Dey | | | ey, Year) 1931 | FRANKLIN, N.C. | | |
| | death with the Maryland one 23e or 28e4 show contact to notified at neral Director | 10a. State 10b. County | | 10c. Cit | y, Town or Lo | cation | | | | 10d. tnside City Limits | | |
| | the Mar | MARYLAND | | | BALTIM | ORE | | | | NA Yes 2 No | | |
| | with the Ma | 10e. Street end Number | | | | 10f. Zip Code | | | 10g. Citizen of | What Country? | | |
| | s 23a | | AD | | | 21207 | | 40 3 44 4 1 | USA | American Indian | | |
| | r items 23. | 11. Merital Status 1 □ Never Married 2 🕅 Marrie | Armed F | cedent Ever in U orces? 2 No | ,S. 13. V | Yas Decedent of f Yes, specify Cu | l Hispanic Origin? Iban, Mexican, Pu | erto Rican, etc.) | | e - American Indian, ck, White, etc. | | |
| 020 | br. or | 3 □ Widowed 4 □ Divorced | If Yes, G | | | | | Specif | AFRO AMERICAN | | | |
| 0 | ed within 72 horygiane. Per than "natural to the Wedeal to the Wedeal Completed | 15. Decedent | | | 16a, Deced | lent's Usuel Occ | upation | undring | 16b. Kind of B | usiness/industry | | |
| Baltimore, Maryland 21215-0020 semit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mantal Hygiane. mportant: If Item 27 is marked other than "natural; or items 23a or 28a-f show | e | (Specify only highest Elementary/Secondery (0-12) | 1 | 1-4or 5+) | (Give kind of work done during most of work life. DO NOT use retired) HOUSE INSPECTOR | | | VOIKING | DAL TI | MORE, CITY | | |
| | tygian her th nt, th | 12 17. Father's Name (First, Middle, L | noth | | HOUS | F INSPI | T | lame (First, Middle | | | | |
| anc | ontal H | | | | | | LOTTI | | PERRY | 110) | | |
| ary. | 2 should be filed vand Mantal Hygie is marked other it summit event, in | JOHN BRADLE | - | | 19b. Mailir | ng Address (Stre | et end Number or | Rural Route Num | ber, City or Town, | , State, Zip Code) | | |
| × | and 2 paith a n 27 is ner trau | MATTIE MARIE | HICKS W | VIFE | 3332 | KERRY | ROAD, BAI | LTIMORE, | MARYLAN | YLAND 21207 | | |
| ore | of He of Hem | 20e. Method of Disposition | 2 Demoval from | | Place of Dispo cemetery, crer | sition (Name of natory or other p | lece) | Date | | - City or Town, State | | |
| Ē | Pages ment of I lant: If Its lury or or | 4 Donation 5 Other (Specify) GARRISON FOREST CEMETERY 2/3/00 OWINGS MILLS, MD. | | | | | | | | | | |
| Sall | permit. Pages 1 and 2 Department of Health 3 Important: If Item 27 Is any Injury or other tra once. | 21. Signature of Funeral Service L | icensee | | ES | TEP BRO | THERS FU | NERALSER | , P. A. | | | |
| _ | 00260 | Just M | - Colley | | 13 | OO EUTA | W PLACE, | BALTIMO | RE, MARY | LAND 21217 | | |
| | Physician /Medical Examiner | 23a. Part 1. Ent to disease, or o shock, or heart failure. List of limmediate Ceuse (Final disease or condition resulting in death) | aniy one cause on | | MY OCA | ARDIAL juence of): | INFAR | | | Interval Between Onset end Deeth | | |
| | axecuted in and itselfransit | | b | Due to /c | | 2515 | | | | | | |
| 60, | | Sequentially list conditions, Due to (or es e consequence of): if the consequence of the course, Enter Underlying | | | | | | | | | | |
| 687 | icate phys is the | Ceuse (Diseese or Injury thet initieted events resulting In death) Last | с | Due to (o | r as e conseq | as e consequence of): | | | | | | |
| Box | ath ce ttendii or use | | d | | | | | | | | | |
| P.O. | 0 0 % | Part ii. Other significant condition | ns contributing to d | leath but not res | ulting In the u | nderlying ceuse | given in Pert I. | | tobacco use co | ontribute to the cause of death? 3 Probably 4 Unknown | | |
| Records, | been s should | | | | | | | | s an autopsy formed? | 24b. Were autopsy findings aveilable prior to completion of ceuse of death? | | |
| | The law ata has page 2. | | | | | | | 10 | Yes 2 No | 1 ☐ Yes 2 ☑ No | | |
| ita | ysicien: The secrificata director, pag | 25. Was cese referred to medical | | | | | 26. Place of [| Death (Check only | • | | | |
| of Vital | 2 00 | examiner? 1 Yes 2 No | Hospital: 1 🔀 | Inpatient 2 | ER/Outpetier | t 3D DOA | Other: 4 Nursing | g Home 5 □ Res | sidence 6 Ott | her (Specify) | | |
| | Attending Ph or death. ector: After thi by the funeral | 27. Menner of Deeth 1 Natural 5 Pending 2 Accident Investig | ation (Mor | 28a. Date of Injury (Month, Dey Year) 28b. Time of Injury M 28c. Injury at Work? 1 Yes 2 No | | | | 28d. Describe | how injury occur | rred | | |
| Division | tal or Attanding P rs after death. st Director: After t led in by the funers Certification: | 3 Suicide 6 Could n 4 Homicide determin | ned 289. Plac | e of Injury - At h ting, etc. (Specil | ome, ferm, str fy) | eet, factory, offic | X8 | 28f. Location City or T | (Street end Num. own, State) | ber or Rural Route Number, | | |
| | To the Hospital or Attanding I within 24 hours after death. To the Funeral Director: Atter completaly filled in by the funeral Medical Certification | (Check only 2 Medical E | Physician: To the examiner: On the b and man | | | vestigation, in m | y opinion, deeth or | | e, date and plece, | and due to the ceuse(s) | | |
| | To un com with | 29b. Signature end title of certifier | ne V. | nom, | mo | A S | 240 23 | 21 - MN 2950 | JANUAR | ed (Month, Day, Year) | | |
| | () | 30. Name and address of person v | no completed cau | Sey 20 | n 23a) (Type, | | alti more | , mp | 21209 | | | |

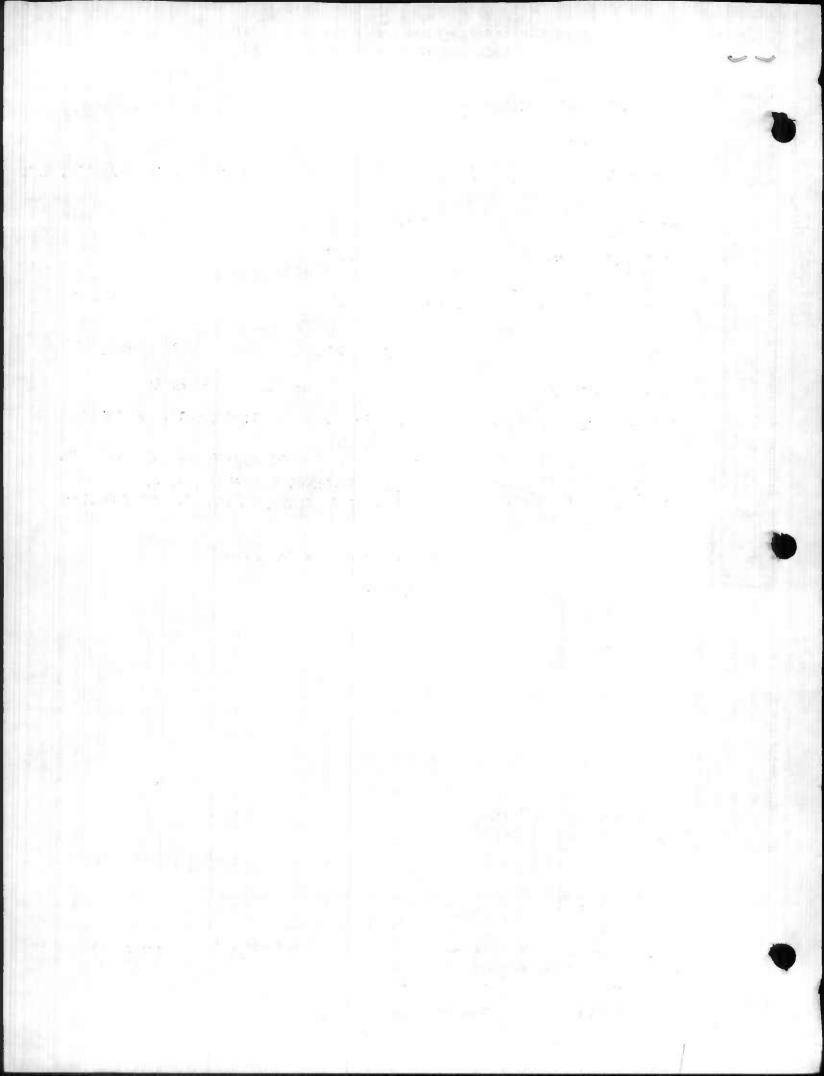
State Registrar

M. NOLAN 6508 Sey 20 Road

31. Date filed (Month, Day, Year)
FEB 0 1 2000 32. Registrer's Signature

Baltimore, mo

DHMH 16 Rsv 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

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| | | TEMS: #23 PART I, | | Certificate of | Death | | eg. No. | | |
|--|--|--|---|---|---|--|---|---|-------|
| | Physician | 1. Decedent's Name (First, Middle, La | | | | 2. Data of Dea Month | th Day | Year 3. Tima of Dea | th |
| | /Medical | EDWARD (| HALL | | 4b. City, Town, or L | Januar | | 000 12:33 | P. |
| | Examiner | University of N | | 1 Center | Baltimo | | | N/A | |
| | * Funeral | - | Sex 7. Age (In yrs. ii | ast birthday) If Undar 1 Yas | r If Under 24 Hrs. | | | 9. Birthplace (State or For | reigr |
| | Director | 220-40-4756 | 1 ₹M 2□ F 56 | Yrs. Months Dey | s Hours Min. | 8. Data of Birth (Month, Dey MAY 31, | 1943 | BALTI:10RE | |
| | 2 | Usuel Residence of Decedent | 140-07- | | | | | | - |
| | anylar show | 10a. State 10b. County | | , Town or Location | | | | 10d. Inside City Li | |
| Я | vith the Maryle t or 28a-f sho be notified at Director | MARYLAND 10e. Street and Number | | BALTIMORE 10f. Zlp Code | | 1. | 1 Ves 2 | - | |
| | E 0 0 | | /AI A\/E | | | | | viat Country? | |
| | fier death w r Hems 23a wher must | 1406 MOUNT ROY | AL AVE. 12. Wes Decedent Evar in U, | 21217 S. 13. Wes Decedent of | Hispanic Origin? (Sr | pecify Yas or No- | USA 14. Rac | e - Americen Indian, | |
| | | 1 Nevar Merried 2 Merried | Armed Forces? 1 ☑ Yes 2 ☐ No | | of Hispanic Origin? (Specify Yas or No- uban, Mexicen, Puarto Rican, etc.) | | | | |
| 2 | o Par | | If Yes, Giva Yaer or Datas: | 1 □ Yes 2 □ N | o Specify: | | Specify | AFRO. AMERI | CA |
| 2 | led within 72 ho ygiene. Ner than "natur it, the Medical Completed | 15. Decedent's E (Specify only highest gr | ducation ada completed) | 16a. Decedent's Usuel Occ (Give kind of work don | e during most of work | king | 16b. Kind of Bu | usiness/industry | |
| 7 | And | Elementery/Secondary (0-12) | Collega (1-4or 5+) | life. DO NOT use reti | | | ACCOLL | NITANT EIDS | |
| 7 0 | | | 4 | CERTIFIED A | | ne (First, Middla, | | NTANT FIRM | - |
| | Mental H Mental H irked off | 45-11115 | | 15 | E LEE | | | | |
| ary | nod M M bu | 19e. informent's Neme/Reletionship | Type, Print) | 19b. Meiling Address (Stre | | | | Stete, Zip Code) | |
| ξ : | und 2 alth a 27 ls r tra | ARTHUR HALL E | BROTHER | 1406 MT. ROY | AL AVE. BA | ALTIMORE | . MARYL | AND 21217 | |
| or or | of He item | 20a. Method of Disposition | 04 | ece of Disposition (Neme of emetery, cremetory or other p | | | | City or Town, Stete | |
| Ĕ | Page nent: M ury o | 1 Suriel 2 □ Cremation 3 □ Cremation 3 □ Cremation 5 □ Other (Special Control of Contro | (y) FI | RST BAPTIST C | EMETERY 1 | 1/22/00 | GUILFO | RD, MD. | |
| | permit. Pa Departmen Important: any Injury once. | 21. Signeture of Funeral Service Lice | nsee an | 22. Name and Add | THERS FUNE | EDAL CED | | | |
| | 205 2 2 | June 1 | m, als | 1300 EUTA | W PLACE, F | BALTIMOR | E. MARY | LAND 21217 | |
| | | 23a. Part1. Enter the disease, or comshock, or heert feiture. List only | plicetions that caused the deeth | . Do not enter the mode of d | ying, such es cerdiec | or respiretory arr | ast, | Approximete Interval Between | |
| F | Physician | | | E ATHEROSCLERO | | | | ASE Onset and Deet | n |
| | /Medical Examiner | Immediate Ceuse (Final disease or condition resulting in deeth) | a. / Caret | ALUGA TELEFO | | | | 1 | |
| H | | | Due to (or | as a consequence of): | | | | | |
| | executed in and ial-transit | Convention list conditions | b. — Due to (or | es e consequence of): | | | | 1 | |
| Ś | cate be executed physician and s the burial-transit edical Examir | Sequentielly list conditions, if any, leading to immadiate ceuse. Enter Underlying Ceuse (Diseese or Injury | 000 (0) | es e consequence orj. | | | | | |
| | re be nysicia | Ceuse (Diseese or Injury that initiated evants | C. Due to for | | | | | 6 | |
| | certificate ding physise as the valuedic | regulting in death) I set | | as e consequance of): | | | | | |
| 0 | 5 6 0 2 | resulting in death) Last | | as e consequance of): | | | | | |
| OXO | th certific tending p or use as | resulting in death) Last | d | as e consequance of): | | | | | |
| DOX O | the attending the attending hed for use a | resulting in death) Last | d | | ylvan in Part I. | 23b. Did to | obacco usa co | ntribute to the cause of de | ieth' |
| O. BOX 0 | the death y the atter sched for a | Part II. Other significant conditions of | d | | givan in Part I. | 23b. Did to | | ntribute to the cause of de | |
| F.O. BOX 6 | es that the death igned by the atter be detached for to by Physician | Part II. Other significant conditions of | d | | givan in Part I. | 1 🗆 Y | 708 2/XNO | 3 Probably 4 Unk | now |
| ords, P.O. Box 6 | requires that the death seen signed by the atter should be detached for u should by Physician | Part II. Other significant conditions of | d | | givan in Part I. | | n autopsy | 3 Probably 4 Unk 24b. Were autopsy findir available prior to completion of caus: | now |
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| VISIOII OI VII. NECOIDS, P.O. BOX 6 | Attending Physician: The law requires that the death ar death ar death. For the function of the state of the state of the function of the state of the function of the state of the function. To Be Completed by Physician illication: To Be Completed by Physician | Part II. Other significant conditions of the same of t | Hospitel: 1 Inpatient 2 28a. Dete of Injury (Month, Dey Year) | ER/Outpatient 3 DOA 28b. Time of Injury M 1 | 26. Place of Dee Diher: 4 □ Nursing H jury at Jork? □ Yes 2 □ No | 24e. Wes a perfor 1 Kry sth (Check only or lome 5 Reside 28d. Describe h | an autopsymed? Ses 2 No ne) ence 6 Oth ow injury occur titreet end Numb | 3 Probably 4 Unk 24b. Were autopsy findir available prior to completion of causi of death? 1 Yes 2 No | now |
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| DIVISION OF VITAL NECONAS, F.O. BOX 6 | the Hospital or Attending Physician: The law requires that the death hing 24 hours after death. This 24 hours after death after this cartificate has been signed by the attention the Funeral Director: After this cartificate has been signed by the attention the Funeral director, page 2 should be detached for a helical certification: To Be Completed by Physician Aedical Certification: To Be Completed by Physician | Part II. Other significant conditions of examiner? 1 Yes 2 No 27. Manner of Death 1 Neturel 5 Panding Investigetic 3 Suicide 4 Homicide 6 Could not to detarmined 10 Conditions of the condition of the condit | Hospitel: 1 Inpatient 2 (Month, Dey Year) 28a. Plece of Injury (Month, Dey Year) 28a. Plece of Injury - At hobuilding, etc. (Specify hysician: To the basis of axaminet | ER/Outpatient 3 DOA 28b. Time of Injury M 1 me, farm, street, factory, officion and/or investigation, In my 29c. Lice | 26. Place of Dee Other: 4 Nursing H jury at fork? Yes 2 No time, dete end place, y opinion, deeth occur | 24e. Wes a perfor 1 XY sth (Check only or lome 5 Resid 28d. Describe h 28f. Location (S City or Tow | in autopsy med? ses 2 No ne) ence 6 Othow injury occur street end Numb m, Stete) cause(s) and me tele end place, 29d. Date signe | 3 Probably 4 Unk 24b. Were autopsy finding available prior to completion of cause of death? 1 Press 2 No ar (Specify) red per or Rurel Route Number. enner as stated. end due to the cause(s) | now |

State Registrar

DHMH 16 Rev 6/95

31. Date filed (Month, Day, Year)

32. Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month 24 Harvin 2000 George Chamberlin 7:00am Jan. 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Prince George Crecent Cities Center Riverdale Hours Min. 8. Date of Birth (Month, Dey, O 5 – 1 4 – If Under 1 Year 9. Birthpiece (Stete or Foreign Country) 5. Sociel Security Number 6. Sex 7. Age (In yrs. lest birthday) Months Deys XXM 2□ F 67 Yrs 578-40-5737 Usuel Residence of Deceden 10e. Stete 10c. City, Town or Location 10b. County 10d. Inside City Limits DC NA Washington 1 ☐ Yes 2 [¾No 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 20001 USA 1556 3rd. Street N.W. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 13. Wes Decedent of Hispenic Orlgin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 11. Maritel Status 1 Never Merried 2 Married 1 ☐ Yes 2 No Specify: Specify: If Yes, Give Yeer or Detes: Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) NA Elementery/Secondary (0-12) Anne Arundel Co. Engineering G.E.D. 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumame) Evelyn Elmer Harvin Hosea 19e. informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 1556 3rd. Street N.W. Washington, DC 20001 Augustus Harvin 20b. Pieca of Disposition (Neme of cemetery, crematory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ₺ Buriel 2 Cremetion 3 Removel from Stete Voshell Mem. Gardens 01-31-2000 Dundalk, MD 4 ☐ Donetion 5 ☐ Other (Specify) 22. Neme end Address of Fecility 21. Signature of Funerel Service Licenses Baltimore, Maryland 21202 WM.C. March FH 1101 E. North Avenue eren plications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, one cause on each ins. 23e. Pert1. Enter the diseeting or odny shock, or heart feilure. List only Approximete Onset end Deeth feril cell corcino Immediete Ceuse (Finel diseese or condition resulting in deeth) + ears Due to (or es e consequence of) metalcopo 4, pleure Due to (or es e consequence of): Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury 4000 thet initieted events resulting in death) Lest Due to (or es e consequence of): Pert li. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco uss contributs to the causs of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings aveileble prior to completion of cause of deeth? 24a. Wes an eutopsy performed? 1 Yes 2 DNo 1 □ Yas 2 □ No 25. Was case referred to medical examiner? 26. Piece of Deeth (Check only one) Hospitel: Other: 4 Divursing Home 5 Residence 6 Other (Specify) 1 Yes 2 10 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Menner of Deeth 28e. Dete of injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Sulcide 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the ceuse(s) end menner es steted. (Check only one) 2 Madical Examiner: On the basis of exeminetion end/or investigation, in my opinion, deeth occurred et the time, date end piece, and due to the cause(s) end menner steted. 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) 025079 200

Examiner The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760. Physician: or Attending F after death. I Director: After d in by the funer 24 hours af Funeral Di letely filled in within 2 To the F

Physician

/Medical

Examiner

Funeral

Director

rait, or items 23s or 28s-f show Examiner must be notified at

pemit. Pages 1 and 2 should be filed within 72 hours effer to Depertment of Health and Mental Hygiene important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, trail Medical Exertment once.

Physician

/Medical

attending physician end for use as the burial-transit

ed by the a

peeu

this certificate hes la director, page 2:

After

Physician/Medical Examiner

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Completed

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Certification:

Medical

Baitimore, Maryland 21215-0020

Director

Funeral

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Be

with the Maryland

death \

State Registrar

31. Dete filed (Month, Dey, Year) DHMH 16 Rev 6/95

DON 14.

30. Name and address of person who completed cause of death (ftem 23e) (Type, Print)

1 word day

75

MD

32. Registrer's Signeture

7404 Executive 11 + 205, Lonhin.

